Using Dialectical Behaviour Therapy to Treat Clients with Left Temporal Lobe Epilepsy

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Abstract

The purpose of this project is to address the gap that exists in the literature in regards to providing counselling to clients with left temporal lobe epilepsy (LTLE). In many ways, the psychological symptoms of LTLE and those of borderline personality disorder are similar. Both client populations can have difficulty regulating emotions and with maintaining healthy relationships. Both populations have high rates of suicidal ideation and depression. Dialectical Behaviour Therapy (DBT) was developed to treat clients with borderline personality disorder. Due to the similarities between many of the symptoms of borderline personality disorder and those of LTLE, counsellors should be successful when teaching the skills of DBT to LTLE clientele. This project provides a description of LTLE and of DBT, and it demonstrates how DBT can be applied to counsel clients with LTLE.

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Chapter One: Introduction

Many articles describe the physical, emotional, and psychological aspects of left temporal lobe epilepsy (LTLE). The authors of very few papers found in my search suggested that there should be counselling, or psychotherapy provided for clients with LTLE. The few that suggested counselling (Andelman, Fried & Neufeld, 2001; Avanzini & Giovagnoli, 2000; Beyenburg et al., 2005) did not give details about what would work or why. Therefore, a gap exists in the research and literature regarding counselling procedures for clients with LTLE, and regarding a theoretical stance to take when providing counselling. Emotional, relational, and communicational difficulties affect the lives of clients with LTLE, therefore research and dialogue regarding counselling practice and theory is essential for thorough client care.

Statement of the Problem

The symptoms caused by partial seizures of LTLE occur in the left temporal lobe, therefore LTLE seizures appear more like psychological symptoms than the seizures most people think of when they hear the word *epilepsy*. As the left temporal lobe of the brain is responsible for language reception and expression, a partial seizure in this area can cause distortions of communication, perception, and emotion. Although the seizure itself may last only seconds, the person experiencing the seizure may experience visual or perceptual changes of his or her surroundings that can last for hours. Immediately before, during, or after a temporal lobe seizure, there may be feelings of panic, depression, confusion, or the inability to understand language. Clients often suffer from depression, anxiety, obsessive

compulsive behaviours, difficulty with relationships and communication, therefore, LTLE is a medical condition for which a counsellor may be able to provide assistance.

Counselling may improve the quality of life for clients suffering through the psychological symptoms of LTLE. Thus, people in the helping professions need information regarding the symptoms of LTLE, and knowledge or academic research regarding counselling strategies to help clients. Knowledge about these symptoms and about counselling theory will enable counsellors, psychologists, and psychiatrists to provide care that may help LTLE sufferers. Counselling might improve clients' personal relationships, communication abilities, and the ability to regulate emotional states more effectively, potentially leading to a better quality of life for this clientele.

Purpose and Questions

My questions are:

1. Dialectic Behaviour Therapy skills are presented in four modules. Would these modules be of benefit to a client with a diagnosis of left temporal lobe epilepsy?
2. DBT skills modules were written for women with borderline personality disorder. Would the worksheets and module handouts have to be modified for LTLE clientele, for men, or for different age groups before they could be used?
3. The emotional, communicational, interpersonal, and psychological aspects of LTLE can increase with stress. Can DBT help the LTLE client by helping to manage stress?
4. Will DBT be an effective strategy to use with LTLE clientele?

In search of the answers to these questions, the first purpose of this project is to inform counsellors about LTLE. Counsellors need to know about the emotional, communicational, interpersonal, and psychological aspects of this diagnosis. Clients can have all, or some of the symptoms of this disorder and symptoms can increase or decrease with life situations such as stress, change, or medication use. The use of medication makes the disorder manageable for some clients. For other clients, the symptoms continue and can become progressively worse due to poor management of symptoms, or scarring of the brain. Professional discussion, and research by counsellors, psychologists, and psychiatrists about LTLE symptoms, and about counselling theory, will enable LTLE clients to access more thorough care. The most important purpose of this project is to discuss counselling for clients with LTLE. This project is a piece of this discussion, and I hope it will stimulate more discussion, academic thought, and research.

A number of considerations should be remembered when reading this project. Right and left TLE sufferers experience different symptoms. Therefore, I will limit the focus of this project to LTLE clientele, with the exception of a brief description of the differences in symptoms between right and left-sided seizures. This discussion addresses LTLE issues that occur prior to brain surgery (called temporal lobectomy). Only some clients are able to attempt a lobectomy as a possible cure for their seizures. Clients undertaking temporal lobectomy to cure LTLE have varied experiences, ranging from permanent cure of seizures, to only a temporary change in symptom status. Because not all clients have temporal lobectomy as a choice, and because not all clients have the same outcome following surgery, this project will discuss clients' possible experiences and symptoms prior to lobectomy.

In Chapter One, I stated the problem, questions, purpose, and boundaries of this project. I will briefly describe the contents of following chapters. In Chapter Two, I describe how I conducted my literature search. This chapter includes parameters that limited the data base search results and identifies the literature chosen. In Chapter Three, I present the medical definition and symptoms of LTLE in detail to educate counsellors about the physical and psychological aspects of this medical condition. I also inform the reader regarding medical diagnosis, and side effects of antiepileptic medications. I briefly compare the symptoms of left and right temporal lobe epilepsy, but only consider LTLE during the later section referring to counselling theory. In Chapter Four, the counselling theory discussed is Dialectical Behaviour Therapy. I describe DBT in terms of history, definition, and skills taught to clients. I describe service delivery of DBT with the four modes of treatment delivery; strategies, and counsellor characteristics; and a summary of the efficacy of DBT. In Chapter Five, I recommend DBT as a treatment for the psychological symptoms of LTLE. Clients can learn to improve the quality of their lives through the psycho-educational skill training included in DBT skill training modules. These skill modules will help clients to work through their symptoms and improve communication skills, emotion regulation, and assertiveness skills. Chapter Six includes concluding remarks for this project and recommendations for further research. The appendices follow the reference list. Each appendix topic contains two lesson handouts, and three worksheets, for use during DBT group counselling. The appendices are not meant to be complete counselling modules. Each appendix worksheet set exemplifies how counsellors can write their own handouts and modify worksheets to suit their own clientele. Following the example of how to modify

worksheets from the appendices in this project will allow counsellors to modify the worksheets originally created by Linehan (1993) for use with different client groups.

Chapter Two: Method of Investigation

Procedures

In the four parts to the search for reference materials used in this project, the first search located information about LTLE using the search term 'left temporal lobe epilepsy.' The second search located information about DBT using the search terms; 'Marsha Linehan,' and 'Dialectical Behaviour Therapy.' The third search located information for the final section of this paper, where DBT is applied to LTLE. In this search, the first two searches were combined with some new terms to increase the likelihood of finding articles about current treatment of LTLE. These new search terms consisted of; 'left temporal lobe epilepsy and Dialectical Behaviour Therapy,' 'left temporal lobe epilepsy and psychological intervention,' 'left temporal lobe epilepsy and psychological treatment,' 'left temporal lobe epilepsy and psychotherapy,' 'left temporal lobe epilepsy and therapy,' 'left temporal lobe epilepsy and counselling,' and 'left temporal lobe epilepsy and clinical management.' After the completion of a draft of the project, a fourth search for additional reference materials occurred.

The first three computer internet searches took place in three sites. These searches utilized the same search terms on both Blackwell Synergy, and EBSCOhost, to look for scholarly journal articles on all three sections of this project. Some duplication of sources occurred, but the search on both sites reduced the amount of articles that had to be ordered from other libraries. The third search occurred through Amazon.ca and Amazon.com to find books to purchase on the topic of DBT. Books on the subject of DBT increased the author's understanding more than articles alone could do.

Boolean search terms entered into the EBSCOhost database search limited the results to include only the most relevant publication sources for the subject based on publication dates, and peer reviewed status. The sources chosen for the database search included; Academic Search Premier, ERIC, Health Source Consumer Edition, Health Source Nursing and Academic Edition, PsycARTICLES, PsycINFO, CINAHL with Full Text, Medline, and Biomedical Reference Collection Comprehensive.

Other parameters entered into the EBSCOhost search limited the results to include only the most recent, or relevant publications. The following parameters limited the results: references available, publication year from 1991 to 2007, scholarly peer reviewed journal, English language, dissertations included, all age groups, exclude book reviews, and population group – human. For a journal article to be used in this project, it had to be referenced, scholarly, and peer-reviewed to ensure that it was a good source of information. The search years were limited from 1991 to 2007 because the advances in technology and brain research over the past decade would leave any older articles too outdated to be of sufficient relevance for use in a current scholarly publication. The author of this paper was interested in exploring treatment of LTLE through counselling, therefore the parameter of 'humans' as the subject was important.

Search Results

Parameters limited search results for this project, yet the result of 831 journal articles left many articles to choose from following the initial two searches completed. I reviewed each of these articles with attention paid in particular to treatment of LTLE, and whether the author addressed counselling as an option for clients. Finally, I narrowed the articles down to

a more workable number for this project by skimming each one to delete repetitions of information.

For the first section of the project, about left temporal lobe epilepsy, the selection of journal articles fully informed the reader while keeping the number of journal articles that overlapped the same information to a minimum. Articles chosen described the following subjects: the detection of LTLE, symptoms of LTLE, family genetics, relationship and marriage status of clients with LTLE, treatment of psychiatric complications of LTLE, and the comparison of right and left temporal-lobe seizures. In total, 20 journal articles form the information base of this section.

For the second section of this project about Dialectical Behaviour Theory, the same method of reading and selection of material took place. Articles for this section described the teaching of DBT skills, how it is used with a number of clientele groups, and efficacy. I chose 16 journal articles, and purchased seven books to complete this section of the project.

In the final sections of this project, where I propose DBT as a treatment for the psychological symptoms of LTLE, I incorporate my own ideas. The worksheets created for the appendices are original. Appendix B: Diary Card is adapted from Marsha Linehan's (1993) original DBT skill workbook. Information for the other worksheets come from the DBT books purchased (Brantley, 2007; Brantley, McKay & Wood, 2007; Linehan, 1993; Marra, 2004; Spradlin, 2003).

The fourth and final search conducted after a draft had been completed occurred on Wiley InterScience to look for sources on specific questions which still needed answering. Parameters used to narrow the search included: journals only, and printed between the years 1991 and 2008. The search term 'divorce and epilepsy' resulted in 14 journal articles. The

search term 'disclosure and epilepsy' resulted in 125 journal articles. The search term 'hyposexuality and left temporal lobe epilepsy' resulted in 72 journal articles. I skimmed the abstracts of these articles, and chose 27 to be read in their entirety. The resulting four articles are cited in this project. It is my hope for this project to be read by counsellors and psychologists, and to be used as a starting point for further research and dialogue about providing appropriate and helpful treatment for LTLE clientele.

Chapter Three: Left Temporal Lobe Epilepsy

The discussion in Chapter Three centers on left temporal lobe epilepsy. First, I will discuss the medical definition, and symptoms of LTLE in detail to educate counsellors about the physical, and psychological aspects of this medical condition. Next, I inform the reader regarding medical diagnosis, and etiology. I then discuss the physical and psychological symptoms of LTLE. In this chapter, I briefly compare the symptoms of left and right temporal lobe epilepsy, but only consider LTLE during the later section referring to counselling theory. Finally, I discuss antiepileptic medications.

Medical Definition

"Epilepsy is the name for occasional, sudden, excessive, rapid, and local discharges of gray matter" (Akimoto, 2004, p.104). Because there are several different kinds of epileptic seizures, epilepsy is regarded as a syndrome rather than as a single disease. Temporal lobe epilepsy (TLE) is the most common seizure disorder. TLE is the seizure type of 40% to 60% of the patients with epilepsy (Bortz, 2003). As the name indicates, these seizures occur within the temporal lobe of the brain. With left temporal lobe epilepsy, seizures occur on the left side of the brain in the temporal lobe. With right temporal lobe epilepsy, seizures still occur in the temporal lobe, but are in the right temporal lobe.

Medical Diagnosis

There are four methods doctors use to make a diagnosis of LTLE. Not all clients will undergo all four of these medical procedures. Two procedures are outpatient while the other two procedures are completed on an inpatient basis. Many clients do not have the second two

procedures because of the time and cost involved. The last procedure involves significant health risks; therefore, unless considering brain surgery to attempt a cure for their epilepsy, few people undergo this fourth diagnostic procedure.

The first procedure conducted for a diagnosis of LTLE is called an electroencephalogram (EEG). An EEG is done to look for spiking or unusual electrical activity in the brain. An EEG is an outpatient procedure, completed at the hospital, where electrodes are placed on the skin. The electrical activity of the brain is recorded at rest, with eyes opened and closed, and for some of the time with flashing lights. The entire procedure takes about 40 minutes to complete. Often no diagnosis is made through an EEG, as there has to be a seizure, or unusual activity recorded during the actual session.

The second procedure used for diagnosis of LTLE is called Magnetic Resonance Imaging (MRI). An MRI is used to produce images recording the density of areas in the brain. An MRI is also an outpatient procedure conducted in the hospital, and takes about 40 minutes to complete. Diagnosis can be made with this procedure if the images show a tumour, brain malformation, or damage to brain areas that may be causing seizures. Up to 30% of patients with temporal lobe epilepsy do not have remarkable changes in high-resolution magnetic resonance imaging, so are unable to obtain a diagnosis this way (Dorfler et al., 2006).

The third procedure used for diagnosis of LTLE is usually completed prior to brain surgery to identify the exact source of seizure activity. This procedure is called Video Electroencephalography, or Continual Video with EEG Monitoring. With this procedure, the client is in the hospital for any amount of time ranging from a few days to a few weeks. Electrodes are glued to the scalp for a continual EEG. The client is in bed and monitored on

camera to record any seizure activity visually, and through brain activity. Diagnosis with this procedure is not 100% successful. A client may not have a seizure while in the hospital, and the EEG does not always clearly show the exact starting point of the seizure. Sometimes, seizures are too deep for an electrode on the skin to give the exact measure of depth of activity in the brain tissue.

The final procedure used for diagnosis of LTLE is the most rarely used. It is called Subdural Electrode Recording. This procedure is similar to the previous procedure; with the exception that the electrodes are not glued to the scalp. Electrodes are placed in holes drilled through the skull, and are then put directly onto the brain to record seizure activity. Although the most reliable for diagnosis, this is an invasive procedure, therefore, there are risks for clients including infections, or bleeding in the brain (Dorfler et al., 2006).

Sclerosis and atrophy are features of long-term LTLE that can be seen on an MRI, and are used for diagnosis. Sclerosis is a hardening of tissues within the brain due to the degeneration of nerve fibres. Atrophy is the wasting away or decrease in size of tissue. Temporal sclerosis is one of the markers looked for when making a diagnosis of LTLE with MRI, as is cell loss in the hippocampus, amygdala, and entorhinal cortex (Bortz, 2003). With long-term seizures, the most common finding leading to diagnosis is hippocampal sclerosis (Babb et al., 2005).

The hippocampus, amygdala, and entorhinal cortex are areas of the brain that are central to our emotional, and learning selves. The hippocampus is responsible for learning and memory, while the amygdala is responsible for the development of memories, and the generation of emotions. The entorhinal cortex is a memory center. As these brain structures

are central to the storage of new information, the development of memories, and the generation of emotions, seizures in these brain areas cause life problems for LTLE sufferers.

Etiology

Temporal lobe epilepsy is often caused by trauma to the temporal lobe, tumours, hippocampal sclerosis, or broken capillaries in the brain; however, genetic factors can play a part. When a family member has epilepsy, there is an increased risk that siblings will also have epilepsy. It has been found that in families with a history of convulsions in infancy, developmental malformations involving the hippocampus may be present. These malformations are formed before birth. The malformed hippocampus increases the likelihood of convulsions in infancy, and then these convulsions contribute to the development of hippocampal sclerosis. The hippocampal sclerosis leads to temporal lobe epilepsy as an adult (Gordon, 1999). According to Burneo and McLachlan (2005), most clients with malformation of the temporal lobe begin to experience seizures during their 20's or 30's.

Physical Symptoms

The seizures of LTLE are slightly different for each individual, as the exact physical symptoms depend on the location, or locations, of the seizures experienced. For many, LTLE seizures are described as an initial feeling of intense fear, a rising sensation in the stomach, nausea, or déjà vu, immediately followed by unresponsiveness, and staring. There is often some kind of uncontrolled movement such as lip smacking, chewing, picking, or arm movement. Clients report the inability to speak throughout these complex-partial seizures,

but they do maintain awareness (Burneo & McLachlan, 2005; Chang, Heo, Lee & Park, 2001; Chen et al., 1999).

Temporal lobe seizures can affect the nervous system in several ways. The eyes can be affected through either mydriasis, or miosis. Mydriasis is prolonged and abnormal dilation of the pupil. Miosis is when the pupil constricts abnormally (Fuerst, Shah, Watson & Zhai, 2005). There may be a change in blood pressure and heart rate during a seizure. The seizure sufferer may experience excessive perspiration, changes in heart rhythm, chest pain, or abdominal pain. Heart arrhythmias are frequently observed, and the cardiovascular system is the most commonly affected autonomic system. Temporal lobe seizures have also been known to cause sudden death, usually due to breathing or heart failure (Elger, Kurthen, Lickfett, Rocamora & von Oertzen, 2003).

Sensations that occur immediately prior to a client being aware that a seizure is going to happen are called auras. Auras may come in the form of visual auras, olfactory auras, or gustatory auras. When experiencing a visual aura, the client may not be able to recognize familiar places or things. For example, when looking in the mirror, the client may not recognize his or her own face. Sometimes, the size, length, or height of objects may appear to change. Olfactory auras are when the client smells scents that are not real. Most olfactory auras are of bad smells such as burned things, medicine, charcoal, rotten oil, alcohol, or the sewer. Occasionally, clients may experience gustatory auras which are when something is tasted that is not real. These tastes are usually unpleasant such as rotten fish or rotten fruit (Chen et al., 2003).

LTLE clients report that changes in memory abilities play a large role in the perceived negative quality of their lives. Damage to the hippocampus causes difficulties with

initial learning, or recall of new information. The greater the strength of the seizures, the more damage there is to this area of the brain, which leads to a greater difficulty with verbal or spatial memory (Avanzini & Giovagnoli, 2000). It has been well established that LTLE is associated with impairment of object naming, remembering names, recall of personal events, and recall of factual knowledge (Bell et al., 2001).

Memory is also affected through faulty temporal ordering or time estimation. As the client fails to remember exactly how events were ordered, the brain combines information from different sources or experiences to form inaccurate memories. Distortions in memory of events are common as the client learns to fill in information that they fail to recall (Bortz, 2003). Distorted memory can be a problem that clients need strategies to manage. For example, if a client is having difficulties managing medications due to faulty memory, the client is at risk of under or overdosing. The client has an inaccurate memory of taking the medication dose, but believes that the dose was taken at the right time. Although the client clearly recalls taking the medication, the memory may be from hours, or even days earlier. Avanzini and Giovagnoli (2000) suggest specific memory training to attempt to improve the daily lives of clients with LTLE.

Sexual dysfunction can also be a symptom of LTLE. "Men and women with epilepsy appear to have a higher incidence of sexual dysfunction than in other chronic neurological illnesses" (Morrell, 1991, p. 38). In men, there may be deficits in both potency, and, or libido. For women, libido can be negatively affected. On the other side of the spectrum, occasionally hypersexuality can be a symptom of LTLE (Morrell, 1991, p. 40). It is believed that sexual dysfunction is caused by social and psychological influences. Epileptic seizures alter the hormones in the pituitary gland and gonads. Decreased hormones can lead to a lower

sperm count, or a low libido. Social behaviour is also influenced by seizures that may restrict social opportunity to engage in sex.

Psychological Symptoms

Depression is the most common psychological symptom of LTLE. Depression is known to have a major impact on the quality of life in patients with LTLE. According to Bortz (2003), the rate of depression for the LTLE population is much higher than it is for the general population. Suicide has the highest mortality ratio of all causes of death among clients with LTLE (Hermann, Johnson, Jones & Seidenberg, 2004; Schmitz, 2005). Depression is a significant contributor to a client's quality of life; therefore, it is imperative that research on antidepressant medication and counselling techniques be available to professionals.

Schmitz (2005) accused clinicians of neglect towards their clients in regards to depression in his study of 70 clients with epilepsy admitted for evaluation prior to surgery. Although 34% of the clients were diagnosed as having 'significant depression,' none of them had ever received antidepressants or counselling as treatment. Schmitz surveyed 67 neurologists with two questions to prove that research and literature on the subject of epilepsy and depression treatment should be done. The first question was, "Do you routinely screen epilepsy patients for depression in your outpatient clinics?" Eighty-six percent of the neurologists answered, "No." The second question was, "If a randomized controlled trial demonstrated that the treatment of depression improved compliance and health-related quality of life in epilepsy patients, would you systematically screen for depression in your outpatient clinic?" The answer was, "Yes" from 85% of the neurologists. Schmitz was

interested in research into antidepressant use. It is important that other avenues of help, such as counselling, and teaching of skills are researched as well.

Another common psychological symptom of LTLE is generalized anxiety disorder (GAD). In a study by Hermann et al. (2004), 52% of 174 clients with epilepsy attending clinics met criteria for the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) description for GAD. The DSM-IV (2000) defines GAD as excessive anxiety and worry occurring for at least six months that is difficult to control. The client must have three or more of the following symptoms; restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and difficulty falling or staying asleep. Some common symptoms of anxiety are sweaty hands, headaches, dizziness, dry mouth, sweating, nausea, or diarrhea.

Canger and Piazzini (2001) discussed the biological and social risk factors contributing to depression, and anxiety for the LTLE client. Biological factors that appear to influence depression, and anxiety for this population are frequency and severity of seizures, and age of onset of seizures. Medication to treat seizures may also contribute to increases in depression, and anxiety. The social risk factors for this population include "social stigma, adverse life events, fear, poor self-esteem, lack of mastery, low rate of marriage and high unemployment, and a history of personal and family depressive illness" (Canger & Piazzini, p. 29).

Many LTLE clients suffer from panic attacks. The DSM-IV (2000) describes panic attacks as short, sudden, and similar to severe episodes of anxiety, intense apprehension, or fear. The client must have four or more of the following symptoms, accelerated heart rate, chills or hot flashes, sweating, shaking, numbness, shortness of breath, chest pain or

discomfort, nausea, dizziness, and fear of losing control or dying. These symptoms are severe and peak within 10 minutes.

LTLE clients may also suffer from obsessive compulsive symptoms. Even when a client does not meet criteria for a diagnosis of obsessive compulsive disorder, counselling for these symptoms can improve quality of life. The DSM-IV (2000) describes obsessive compulsive disorder as an anxiety disorder. The client suffers from repetitive, intrusive, and persistent thoughts or behaviours that the client feels a strong need to continue. Repetitive thoughts are called *obsessions*, while repetitive behaviours, such as obsessive hand washing, are labelled *compulsions*. The obsessions experienced cause the client great distress. Compulsions are followed through to reduce distress. The compulsive act is not realistically connected with the distress, or is excessive; therefore, the distress is not reduced. The client is aware that these obsessions and compulsions are excessive, yet feels the need to continue.

Depression, anxiety, panic attacks, and obsessive-compulsive symptoms are all psychological symptoms of LTLE that can be alleviated with counselling. Clients can suffer from these symptoms due to fear about recent seizures, or anxiety about having seizures in the future. Some of these symptoms will remain despite counselling, as the brain, and seizures themselves are responsible for some of these emotions. The epileptic activity begins in the amygdala, which is responsible for processing, and relaying emotional information. These seizures cause the message of anxiety, fear, or panic to be passed to the rest of the brain (Beyenburg et al., 2005).

Seizures of LTLE can often cause personality changes that can damage the client's relationships with family, friends, and others, sometimes having a significantly negative effect in the client's life. When the personality change is mild, the client may seem irritable,

stubborn, or petty. With moderate personality change, the client can appear to be unsociable, prone to hold a grudge, and inclined to conflicts. Clients with severe personality changes find contact with others difficult. They can come across as spiteful, aggressive, and intolerant of others. These seizures can cause deterioration in family and friend relationships, and clients are often unable to deal well or appropriately in crisis situations (Eroshina, Gromov & Mikhailov, 2005).

Comparison of Right and Left Temporal Lobe Epilepsy

There are differences and similarities between right and left temporal lobe epilepsy symptoms due to the location of seizure activity. The temporal lobe is responsible for memory and emotion, therefore, right and left temporal lobe seizures will both cause emotional or memory difficulties. The symptoms will be different because the right and left side of the brain are responsible for different activities within the domains of memory and emotion.

Due to seizure involvement of the amygdala — responsible for regulating emotions — left and right TLE clients will have different emotional symptoms. Clients with left TLE will frequently display catastrophic reactions for even small events, while patients with right TLE have a tendency towards joking, and reactions of indifference, even when they should be serious. Left-sided seizures cause deficits in processing of positive emotions, and often lead to increases in anxiety, and depression. Seizures of the right-side of the temporal lobe can cause deficits in processing of negative emotions, and can lead to mania, neglect of oneself, and an unawareness of the importance of symptoms (Andelman, Fried & Neufeld, 2001). Due to the higher levels of anxiety, and depression in left-TLE sufferers, and the lack

of attention to symptoms in right-TLE suffers, appropriate counselling is important to keep the emotional aspects of TLE in check.

An example of how these two populations can respond differently to the same situation was seen in the test administration conducted by Andelman et al. (2001). Three of the LTLE clients but none of the RTLE clients displayed catastrophic reactions such as crying, and pessimistic attitudes during the interviews. The LTLE clients worried over cognitive deficits that neurocognitive testing showed to be not significant, while the RTLE clients did not have this same worry.

The hippocampus is responsible for learning and memory; the differences between symptoms concerning memory for LTLE and RTLE clients show how the two sides of the brain work differently. People with left-sided seizures involving the hippocampus have difficulty with verbal memory, while people with right-sided seizures have difficulty with visual-spatial memory. For example, a client with LTLE may have difficulty remembering names of people or objects. This client might have an impaired recall of conversations, or might repeat the same question without realizing it. Clients with RTLE might have difficulty recognizing familiar faces, or they might misplace personal items often, or become lost in familiar places easily (Babb et al., 2005; Bortz, 2003).

Kim, Kim, Son and Yi (2003) used the Wechsler Intelligence test to compare right and left TLE client intelligence scores to show the differences in the functioning of the right and left temporal lobes. As the temporal lobe is critical for forming new memories and consolidating new information, they believed that the test scores would exemplify the damage done to the temporal lobe area through higher overall scores in certain areas. The testing results showed that in the LTLE group, the Verbal Comprehension (VC) score was

significantly lower than the Perceptual Organization (PO) score. These results were reversed for the RTLE group. The results also showed that LTLE clients may have deficits in verbal intelligence, while RTLE clients might have deficits in nonverbal intelligence. An interesting finding during testing was that RTLE clients scored lower for Digit Span and Arithmetic than the LTLE clients. RTLE clients also scored lower in Working Memory scores. These results suggested that the left side of the temporal lobe was responsible for math, and had more working memory capacity than the right temporal lobe.

Antiepileptic Medications

Medication schedules and dosages are often monitored by a psychiatrist due to the many psychiatric side-effects of antiepileptic drugs. There are many antiepileptic drugs, such as: Benzodiazepine, Carbamazepine, Ethosuximide, Felbamate, Gabapentin, Levetiracetam, Pregabalin, Phenytoin, Tiagabine, Topiramate, and Valproate. Each of these medications can cause psychiatric side-effects. Felbamate can cause depression, agitation, psychoses, irritability, anxiety and panic. Like Felbamate, Benzodiazepine can cause irritability and depression, but may also cause cognitive impairment or confusion, and it is also addictive. Carbamazepine can cause irritability, depression, manic episodes and sexual dysfunction. Sedation and psychoses can be caused by Ethosuximide, Gabapentin, Levetiracetam, Pregabalin, Phenytoin, Tiagabine and Topiramate. Lamotrigine can cause irritability and insomnia, and Phenytoin, Tiagabine and Valproate can cause depression (Beyenburg, Elger, Mitchell, Reuber & Schmidt, 2005). Due to the many serious side-effects of anti-epileptic medications, taking or changing medication can add to the symptoms experienced by the LTLE client.

Unfortunately, the common LTLE symptom of anxiety is difficult to treat with medication for this clientele. Beyenberg et al. (2005) described the current treatments for anxiety, and problems for LTLE clientele. Anxiety disorders are often treated with antidepressants such as selective serotonin reuptake inhibitors (SSRIs), reversible monoamine oxidase inhibitors (MAOIs), serotonin-noradrenaline reuptake inhibitors, or tricyclic antidepressants. Antidepressants have been found to increase seizures. Therefore, treating anxiety that is caused by seizures with a medication that is likely to increase seizures may not be the best course of action. Beyenberg et al. notes that "to date there are no controlled studies of the medical therapy of anxiety disorders in patients with epilepsy" (p. 167). Research in this area is necessary for more informed treatment of anxiety for LTLE clients. There is also a need for research into non-drug interventions such as counselling interventions that work for reducing anxiety for LTLE clientele.

To Disclose or Conceal?

The question of when, how, and to whom a diagnosis of LTLE is disclosed, is different for each client. In their study of 82 women, Kumar, Radhakrishnan, Santosh and Sarma (2007) found that 55% concealed, while only 45% disclosed their diagnoses when they were engaged to be married. Kumar et al. noted that "the majority of those who concealed admitted that they did so fearing breakup of marriage negotiations, and the majority of those who disclosed did so to forestall the consequences after marriage of concealing" (p. 1007). Of the women in this study, seven clients kept their diagnosis a secret for between 6 to 13 years of marriage. Divorce and separation rates were significantly higher in the group who concealed their diagnosis prior to marriage (Kumar et al., 2007).

Troster (1997) wrote, "Having epilepsy is not just a medical diagnosis, it is also a possible stigma" (p. 1227). As long as seizures are under control, the client can choose to disclose, or conceal, as their epilepsy is not a visible condition. Troster's findings, from a group of 119 outpatients, were that the client only discloses to close family members, and a few other trusted people. Troster concludes that "persons with epilepsy generally strive to conceal their disease to the greatest degree possible because of their fear of stigmatization" (p. 1227). The more the client views the epilepsy as a stigma, the less likely he or she is to disclose. Overall, clients with LTLE disclose only when disclosure is necessary as a preventative measure in the case of some possible negative outcome for not disclosing (Troster, 1997, p. 1236).

The many symptoms of depression, anxiety, fear, obsessive compulsive thoughts, emotional instability, confusion, memory difficulties, and hallucinations can occur in any combination for LTLE clients. The psychological symptoms of LTLE can be due to the actual seizure event in the brain, negative side-effects of antiepileptic medication, or anxiety about past or future seizures. Enduring these symptoms can be difficult. Counselling to help with communication, relationship difficulties, memory problems, depression, anxiety, fear, obsessive compulsive thoughts, emotional instability and confusion is essential to help this population of clients lead more stable and happy lives.

Chapter Four: Dialectical Behaviour Therapy

Due to the many psychological stressors that may be experienced, counselling should be a considered intervention in the treatment of people with LTLE. First, I give an overview of the therapy, followed by its history. Next, I discuss the therapy in terms of Linehan's Biosocial Theory. I discuss service delivery of DBT with the four modes of treatment delivery, the five stages of treatment, the four skills modules, strategies, and counsellor characteristics. Finally, I discuss a summary of the efficacy of DBT.

Overview of DBT

DBT is a cognitive behaviour therapy. Standard cognitive behaviour therapy focuses on helping clients change their thoughts, feelings, and behaviours. DBT is a cognitive therapy, as there is a focus on identifying styles of thinking, such as maladaptive thinking, automatic thoughts, or ruminating. The DBT counsellor utilizes cognitive therapy techniques such as: looking at the order of thought processes, and self-monitoring diaries. DBT is a behavioural therapy, as there is an emphasis on skills, and problem-solving strategies. The therapy is very structured with individual sessions, and different educational modules of skills for the client to learn and practice.

DBT moves from the path of standard cognitive behavioral therapy by including mindfulness, dialectical philosophy, and the importance of the therapeutic relationship. Teaching a client mindfulness practice is central to every aspect of DBT. When practicing mindfulness, the client tries to quiet the mind to focus on seeking peace and balance in all areas of life. To be mindful is to find a middle ground between the extremes of the emotional mind, and the logical mind. Linehan (1993) explains that "wise mind is the integration of

emotional mind and reasonable mind" (p. 66). This resulting middle ground has the client living and making decisions, experiencing and responding, using logic and reason, emotional experience, and intuitive knowing in balance.

The two most important principles of dialectical philosophy are: everything is interrelated, and everything has its opposite. In the dialectical philosophy, all people are part of the same whole, therefore, are connected. What this means is that it is not possible to live a life unconnected from others. Our behaviours influence others and their behaviours influence us. The second important dialectical principle is called *polarity*. For every feeling or opinion we can experience, there is an opposite. When something exists on an opposite pole, there is natural tension between these poles as the opposites fight to maintain a balance. The principle of polarity is used in DBT in several ways. An example of the use of polarity is when there has been an argument in the client's life. The client and other person in the conflict have completely opposing opinions, yet both can be right at the same time. Through counselling, the client learns that both people can be right in some way at the same time without losing face; therefore, communication can improve. Much of the client change in DBT comes about because of the internal tension created from polar opposites within the client's life (Peck & Smith, 2004).

Through DBT, clients learn a skill base to improve their lives. Marra (2004) gives an excellent definition of what DBT can do for clients. He says,

> DBT will assist you to better regulate your emotions to serve your goals, help you to face your feelings without terror, increase your sense of personal identity, improve your judgement, sharpen your observational skills, and reduce the sense of crisis in your life (p.9).

With DBT skills, clients learn about identifying and analyzing feelings, and conflicts in life. They learn about making choices that work through problem solving for conflicts, and learn about competing-dialectical needs and wants. DBT skills help clients understand that all feelings are valid, and are pieces of information to be considered when making choices. These skills demonstrate a new way to deal with overwhelming feelings, and interpersonal conflicts, that will reduce stress, and prevent crisis. Clients learn to set goals, to use strategies to change behaviour, and to make improvements in feeling and thinking.

The client-counsellor relationship is warm, and genuine. The intent of the DBT counsellor is to help the client find the motivation to build a life that includes lasting relationships, and anything else that provides meaning to the individual's life. Together, they are reaching toward the goal of making a life that is worth living. The relationship is considered to be so important that, if a client displays behaviours that get in the way of this therapeutic relationship, other counselling is put on hold until the problem is resolved (with the exception of life-threatening behaviour). Behaviours that get in the way of the therapeutic relationship are called therapy-blocking behaviours in DBT, and are considered just as serious as self-harm (Bellows et al., 2007).

DBT is a blend of cognitive behavioral interventions, Zen mindfulness practice, and dialectical philosophy. The focus of DBT is on the balance between acceptance, and validation of the client. The counsellor-client relationship is very important; therefore, treatment decisions, or change and problem solving processes are very cooperative activities. The approach is education-based, and includes an emotional skills training group therapy component. Through group and individual counselling, the client learns to problem solve, regulate emotions, and make change to lead a better quality of life.

History of Dialectical Behaviour Therapy

Dialectical Behaviour Therapy was originally developed and tested by Marsha Linehan, and her colleagues at the University of Washington, as a treatment for women with borderline personality disorder (BPD). As Linehan reflected on her experience working with women who were emotionally distressed and chronically suicidal, she found that traditional cognitive behaviour therapy was not always successful. She wanted a counselling therapy that would work for clients suffering from intense emotional disregulation. Linehan developed DBT, and then conducted clinical trials comparing DBT to treatment-as-usual (TAU) services. TAU services refer to the psychotherapy that hospitals or counselling centers regularly offer clients which typically include; Behaviour Therapy, Cognitive Behaviour Therapy, Person-Centered Therapy, Feminist Therapy, or Family Systems Therapy. DBT has been found to be more effective than TAU in the reduction of client dropout, suicidal and self-harm behaviours, anxiety, and hospitalizations. DBT has also been found to be more effective in increasing interpersonal functioning (Wolpow, 2000).

Marsha Linehan began treating BPD women with standard Behaviour Therapy, and Cognitive Behavioural therapy, but found that something was lacking for her clients. Linehan found that the strong focus on change did not work with BPD clients. These clients often felt invalidated or criticized, and would then drop out of counselling. On the other side of the spectrum, she also learned that a treatment focusing too strongly on acceptance did not work either. Her clients felt that their suffering was not taken seriously, so they did not feel the urgent need to produce change. Following these two important discoveries, Linehan developed DBT, which encourages both acceptance and change in balance (Chapman, Kuo,

Linehan, Lynch & Rosenthal, 2006). Linehan's first DBT manuals were published in 1993, as a comprehensive program for women diagnosed with BPD.

Although originally developed in 1993 for women clients with BPD who were not currently staying in hospital, DBT has been adapted for different clientele and settings. BPD has been adapted for use with inpatient groups, both men and women together, and a variety of age groups including adolescents and the elderly. DBT has been used and evaluated with success in Britain with BPD clients. This counselling therapy has also been adapted for use with women with substance abuse and dependence, and for women and teens with eating disorders. BPD has been evaluated as useful with offenders in a jail setting (Barkham et al., 2003).

As DBT was originally created as a treatment for women with borderline personality disorder, understanding emotions is an important topic. Clients with BPD are emotionally distressed, have difficulty regulating their emotions, and are chronically suicidal. The understanding of the cause of these emotions is important for the treatment of these individuals.

Linehan's Biosocial Theory

Linehan's Biosocial Theory is about the causes of emotions within the framework of DBT. Biosocial Theory explains the interactions between emotions, the environment, and biological factors. Emotions are viewed as a full body and brain response rather than simply being the individual's experience of the emotion. Emotions include the action associated with the emotion such as withdrawal with sadness, or flight with fear. Emotions also include biochemical changes in the brain and body such as changes in heart rate, or body

temperature. Emotions can be prompted by internal or external factors. Emotions function to organize thoughts into categories that make sense to people. When this happens, individuals are able to understand the personal significance of events. Emotions also function to motivate actions, or behaviours. Emotions direct an individual's attention to the events in the environment that are the most personally important, and inform the individual of events to run from, or enjoy (Beyer et al., 2007; Dimeff & Koerner, 2007).

Four Modes of Treatment in Dialectical Behaviour Therapy

DBT is structured into four modes of treatment. The client accesses *individual counselling* and scheduled *phone consultations* with an individual counsellor, and *skills group training* with a pair of counsellors. Once per week, there is a *team consultation meeting* for all counsellors practicing DBT in the same building. The individual session occurs once weekly, and functions to target specific client behaviours and problem-solve for real life events based on what happened for the client over the past week. Phone consultations occur with the individual counsellor to help the client solve problems, and use DBT skills in real-life situations. The two-hour skills training group is provided weekly. Group is less individual-specific, and is about learning and strengthening skills to regulate emotions, and to have better relationships.

The DBT process starts with the client and individual counsellor discussing the therapy and what the commitment to using DBT would mean for each of them. During this first session, the counsellor makes a commitment to the client and the client to the counsellor, to work on positive change. This initial commitment to DBT is to try learning, and using the

skills for one year. After a commitment is made, the client and counsellor work cooperatively to identify specific problem behaviours that will be addressed during individual sessions.

Individual therapy and phone consultations are used to learn and practice skills learned in group. During individual sessions, skills are practiced through reviewing occurrences of targeted behaviours, and the consequences of these behaviours, as well as any skills used during these events. The counsellor acts as a coach to help the client to make change, and to use new skills to create a life worth living. Phone consultation is used to help the client take the skills learned in group, and practiced in individual counseling, to the real world. Some counsellors give clients permission to phone when needed, as long as the privilege is not abused. Other counsellors schedule a phone-in time for clients to call on a weekly basis to quickly talk about skills used that day. The purpose of telephone consultation is to increase problem solving and skills use, to learn how to ask for help appropriately, and to repair recent problems in the client-counsellor relationship. If a client threatens suicide on the phone, the counsellor quickly gets off the line, and calls for emergency services. It is important that the client understands that phone consultation is not to be used as an emergency, or suicide line. Phone consultation is meant as a real-life opportunity for coaching of DBT skills, and coping behaviour.

The DBT skills group is a teaching group that follows the structure created in Marsha Linehan's manuals written in 1993. There are four sets of skills to be learned. Each of these sets of skills is presented in an individual module. There is a break between each module to give time for clients to practice new skills, with coaching from individual counsellors. The *Core Mindfulness Skill Module* is presented first. It is reviewed at the end of each module because mindfulness is seen as a building block for all other skills learned. Mindfulness

involves being present in the moment, while remaining nonjudgmental. The *Interpersonal Effectiveness Skills Module* is presented second. This module is mostly assertiveness training, and self-respect building. Clients learn how to say yes or no, and to solve interpersonal conflicts without damaging relationships. The *Emotional Regulation Skills Module* is the third set of skills learned. These skills enable the client to identify and accurately describe emotions, and their triggers. Clients learn to reduce their vulnerability to negative emotions, and to increase positive emotions in their lives. The *Distress Tolerance Skills Module* is the fourth and final module of skills learned. These skills focus on living life in the moment, and tolerating crisis moments when they cannot be changed. The client is taught about effectively managing difficult feelings, and events. As these moments are the most difficult with which to deal, it is imperative that the module come last, and be reinforced with mindfulness skills.

To help individual counsellors work effectively, the group of counsellors in a workplace function as a team. If a client brings an issue to an individual session that is difficult to resolve, the counsellor talks to the team. Each week, there is a scheduled consultation team meeting for 60 to 120 minutes. At this meeting, the team debriefs, and works on skills so that each individual counsellor is doing the best job he or she can for the individual client. The focus is always on the client's point of view. Although there is a team, the ultimate responsibility for each client remains with each individual counsellor.

The main focus of discussion during team consultation meetings is the behaviour of each individual counsellor. Client-counsellor transactions are the focus rather than client difficulties, as each counsellor works toward creating better relationships with clients. Team members support and coach each other to assist with effective treatment by highlighting and targeting counsellor behaviours that might influence client treatment. Examples of counsellor

behaviours that could be targeted are: lateness, being judgmental, mindfulness, or lack of preparation. The counsellor's behaviour is targeted in the same manner by the team as the individual counsellor coaches the client. Targeting of counsellor behaviour helps to reinforce effective counsellor behaviour, and skillful treatment (Chapman et al., 2006).

Five Stages of Treatment in Dialectical Behaviour Therapy

Treatment is structured both across and within sessions. During the initial appointment, the counsellor and client collaboratively list a hierarchy of the client's target behaviours. At the beginning of each session, they look over problem behaviours of the past week, and then collaboratively set a session agenda based on these behaviours. Structuring of treatment in this way is important when working with borderline clients because these clients will rarely come to a counselling session with only one problem, or one target behaviour.

DBT is structured across sessions with the use of five stages. The first stage for all clients is *Pre-treatment*, which is followed by one to four stages. Pre-treatment is the commitment stage of counselling. DBT is explained to the client, and the client and counsellor make a year-long commitment to each other. Following commitment, the goals and methods of individual therapy are agreed upon collaboratively. The client must agree to try to decrease suicidal or self-harm behaviours, to work on interpersonal difficulties that interfere with counselling, and to practice behavioural skills learned in group. A counselling relationship is not fully established until the client agrees upon these three points. The five stages of DBT are presented linearly, but client progress is often not linear, therefore, the stages may overlap. For example, after a hard week, a counsellor might need to go back to a

session that appears much like Pre-treatment to regain a commitment to DBT goals or methods.

The second stage of DBT is called *Stage I*, and is about safety, stability, and connection to others. The counsellor tries to help the client gain control of life by learning to control thoughts, emotions, or behaviours that were targeted for change. Certain types of behaviours are worked on in order of priority. Suicidal behaviours take first priority during a session. Second priority behaviours are those that interfere with counselling, or with the counselling relationship, or self-harm behaviours. Third priority behaviours are any that interfere with the quality of life of the client such as major problems with relationships or employment. The final priority is to learn to apply or to practice the skills learned during group sessions.

The third stage of individual counselling with DBT, called *Stage II*, is about exposure, and emotionally processing the past. This stage may be simple or extreme, depending on the client's history. In some cases, this stage could include reducing post-traumatic stress disorder symptoms. In less extreme cases, this stage might be about dealing with past trauma that still enters the client's decision-making process. Some other therapies deal with the past first, and then move on to the present. DBT counsellors never allow clients to deal with traumas of the past first. The belief is that clients need to learn skills to be able to work through emotions that will emerge or the client may not be able to resolve the trauma successfully. When all skills are learned, the client will be able to cope with the intense emotions involved with the trauma of the past.

The fourth stage of DBT, labeled *Stage III*, and is a synthesis stage. During this stage, clients learn to set and achieve individual goals. The client works on self-respect and self-validation. There is less reliance on the counsellor validating the client. Work at this stage is about setting goals for independence, and plans for when there will no longer be a need for counselling. The client learns to be more independent when dealing with thoughts, emotions, and behaviours, and to trust themselves.

The fifth stage, called *Stage IV*, is about developing the capacity for sustained joy, or spiritual fulfillment. Many clients end counselling before this point, as the problems they were experiencing have been resolved, therefore, they feel no need for further help. Discussion at this stage goes beyond the problems of daily life, and is about client feelings of incompleteness. Counsellor and client work together to find answers to existential questions that the client considers important (Heard, Swales & Williams, 2000).

Four Skill Modules Taught in Group

A DBT skills group is presented in four modules. Each module is delivered in an eight-week format, which results in 32 weeks of skills training. The four modules are: mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills. Session one is an orientation to skills training. Session two is an introduction or review of core mindfulness skills. Sessions three through seven are lessons specific to the module being taught. Session eight is a wrap-up session. There is a break between each module to practice the skills learned in the past module.

Skills group is presented in a two-hour session once per week. During the first half of a group session, the new skill is introduced through lecture, hand-outs, and mini-dramas by the two co-counsellors. During the second half of group, clients work with the new skill through discussion, and worksheets. New skills covered in group are to be practiced in real-life situations over the following weeks, and discussed during individual counselling sessions with the individual case counsellor (Peck & Smith, 2004).

Core mindfulness skill module. The Core Mindfulness Skill Module is presented first, and then reviewed following each module to increase client awareness and effectiveness while other skills are practiced. During this module, clients learn skills to focus and control attention, and awareness on observing oneself or one's immediate environment. They learn to fully and accurately describe these observations. The final goal is to participate fully in the present. Through mindfulness skills, the client learns to think with a non-judgmental stance through moment-to-moment observation. The client develops more effective thoughts, emotional reactions to stimuli and behaviours by focusing on what works in different situations (Chapman et al., 2006).

Marsha Linehan adapted the main skills for the Core Mindfulness Skill Module from aspects of Zen Buddhism. The main idea of being mindful is to become aware of thoughts during a variety of activities to work from the *wise mind* — the middle path between the *reasonable mind,* and the *emotional mind* (Heard et al., 2000). When being mindful, clients are non-judgmentally observing their own behavioural, emotional, and thought responses to the environment. The client is less vulnerable to emotional distress when thinking from a wise state of mind because the client is coming from a balanced place of reason and emotion.

Teaching clients to increase mindfulness of current emotional experience helps them to see what behavioural reactions are effective, and which ones are not. Over time, being mindful can help to extinguish behaviours, thoughts, or emotions that are ineffective, or that were previously used as avoidance responses (Chapman et al., 2006; Dimeff, Korman & McMain, 2001).

Interpersonal effectiveness skills module. The skills learned during the Interpersonal Effectiveness Skills Module teach the client to be more effective during interpersonal conflicts. These skills are primarily assertiveness skills to enable the client to ask for what they need, or to say yes or no appropriately. Counsellors stress that it is important to maintain relationships, and self-respect, during conflict. Clients are provided with examples and worksheets to practice being effective when the needs and wants of others conflict with their own needs.

The Interpersonal Effectiveness Skills Module teaches clients how to be more effective in their personal relationships. The skills learned help the client deal with feelings such as fear of abandonment or anger, that lead to interpersonal chaos. Clients learn to identify three main aspects of every interpersonal situation so they are better able to prioritize the importance of each situation in which they find themselves. The three aspects are: (1) the objective, (2) the relationship issues, and (3) self-respect. Clients are taught how to work through interpersonal interactions based on the priorities or worries identified by the three aspects. Skills are practiced to maintain self-respect in different types of interactions, with different relationship issues, and objectives. For example, if the client identifies that there is a conflict, but wants to keep this relationship, the client's opinion in the conflict is important,

but not as important overall as keeping the relationship intact. In this situation, the client will use *GIVE* skills. *GIVE* is an acronym for the skills that the client will remember to use in the situation. The client will be *Gentle*, and try to appear *Interested* in the other person's opinions. The client will be sure to *Validate* the other person's feelings, beliefs, and points of view. Finally, the client will attempt to remain *Easy* in manner to effectively work through the problem (Heard et al., 2000).

Emotion regulation skills module. The third DBT skills module is the Emotion Regulation Skills Module. Clients are taught behavioural and cognitive strategies to regulate excessive emotions that are not working in their lives. These skills help clients to reduce avoidance of emotions, excessive anger, or sadness — therefore helping clients feel more in control of everyday situations. Clients are taught skills for reducing ineffective emotional responses, and reactional behaviours that are impulsive and affecting quality of life. Skills are taught to help the client deal with emotions in a healthy way rather than avoiding negative emotions, and how to change these negative emotions if they are unnecessary. Overall, the most important part of this module is learning how to increase the amount of positive emotions experienced.

The Emotion Regulation Skills Module teaches clients about intense emotions in terms of observing emotional events, describing what happened, and accurately labelling emotions. Learning to label emotions accurately is important as this module is about the experience of intense emotions. If a client describes an emotion as *sad* for an intense moment, the client is taught vocabulary to more accurately describe what was felt at the moment such as *despondent,* or *frustrated,* before moving on to deal with the situation.

Clients are taught to identify situations, people, or stimuli that precede and follow these intense emotions to understand the cause of these emotional reactions. They are asked to look for patterns in their own behaviours or emotional responses that are problematic in their lives. For example, if a client is often angry, the client is asked to look at what was happening internally, and externally, before the anger started. Was the anger a reaction to someone else's behaviour? Was there another possible reaction to that behaviour? What was the other person's reaction to the anger? The client is taught that the typical reaction to anger is either withdrawal, or anger redirected back. By observing and describing what happened, the client might be able to find a new behaviour, thought, or emotion, to try the next time the same situation occurs.

Reducing emotional vulnerability is an important part of this module. Clients learn about factors that will add to their own vulnerability such as stress, poor diet, or lack of sleep. Clients are asked to pay attention to sleep habits in order to develop a regular sleeping pattern. Proper eating is discussed as a way to keep the body and mind healthy. Individuals spend time considering ways to reduce personal stress through pleasurable activities. An attempt is then made to incorporate these activities into daily life to reduce emotional vulnerability, and in turn decrease emotional suffering (Dimeff et al., 2001; Heard et al., 2000).

Distress tolerance skills module. The final skills module taught during DBT group is the Distress Tolerance Skills Module. The skills learned during this module help to reduce suicidal thoughts, self-harm, and impulsive behaviour. Clients are taught that some negative moments cannot be avoided or changed. They learn to cope with intense negative emotions

with skills that help them accept the emotional pain in those moments. Clients learn strategies such as self-soothing, distracting, and effective breathing to deal with distressing moments with better self-control, and more functional behaviour. The most important point in this module is that the client can get through an unavoidable negative moment without resorting to self-harm to cope (Dimeff et al., 2001; Dimeff & Koerner, 2007; Heard et al., 2000).

Dialectical Behaviour Therapy Strategies

DBT utilizes a number of strategies that are common to other behaviour therapies. *Exposure* to an object or situation that brings up an undesired response such as anger or fear is commonly used. The client uses mindfulness skills to be aware of reactions in the moment as exposure to the stimuli is slowly increased over time. With time, the undesired emotional or behavioural response is changed. *Skills training* is an essential part of DBT that is core to other behaviour therapies. It is through the practice of these skills that the client learns new emotional responses, and thought or behaviour patterns. DBT and other behaviour therapies use *reinforcement* to increase positive change. *Cognitive restructuring* is also a commonality. The belief is that the restructuring of thought patterns is the most important mechanism to changes in behaviours. Strategies that are unique to DBT are *chain analysis, dialectics, validation* and *acceptance* (Chapman et al., 2006).

Chain analysis. One of the main change strategies used in DBT is the chain analysis. This is a problem solving strategy that is utilized during most individual counselling sessions. In the initial session, the client and counsellor collaboratively set target behaviours.

Throughout therapy, the client uses a diary card (Appendix B) to monitor and document the target behaviours, and DBT skills, observed throughout the week. At the beginning of each counselling session, the client and counsellor collaboratively set a session agenda based on the target behaviours and skills documented on the card. During the session, one or more of the target behaviours are analyzed in-depth through a chain analysis which will consider the factors that occurred before, during, and after the target behaviour. The goal of a chain analysis is to create a complete and accurate description of the emotional, behavioural, and environmental events associated with the target behaviour.

The chain analysis looks at every small detail between the environmental triggers, and the target behavioural reaction, including the events that follow the target behaviour. It is called a *chain* analysis because it describes events, and feelings, reactions, thoughts, behaviours, or consequences as links in a chain that are all connected. It is important to consider that the original environmental trigger identified may not be the only explanation for the following behaviour or emotional reaction. Behaviours and emotions may be patterns, or may be linked to past trauma. The chain analysis must be conducted with enough detail to explain the client's thought process, emotional reactions, and behaviour prior to the target behaviour, during the episode, and during the consequences, to fully explain what happened.

As the behavioural chain analysis is conducted, the counsellor simultaneously gives an alternative solution analysis to coach the client in effective problem solving. Through the alternative solution analysis, the client and counsellor collaboratively discuss points in the chain where the problem could have been dealt with differently in terms of emotional, or behavioural reactions. The client and counsellor discuss skills that have been learned that could be used in future similar situations. The two key goals of an alternative solution

analysis are to explore positive change, and to watch for factors that might interfere with the use of skills in the future (Chapman et al., 2006; Dimeff & Koerner, 2007; Heard et al., 2000).

A chain analysis is discussed in fine detail to increase the likelihood that the client will learn how to deal with problem stimuli in more functional ways. The following is an example of a chain analysis. The client comes to an individual session with the target behaviour of *cutting* documented on her Diary Card for last Tuesday. She also reported on the card that she did not use any DBT skills during the incident. Collaboratively, the client and counsellor decide that this will be one of the incidents that will be discussed in a chain analysis. This 18 year-old client came home from school to find her unemployed father in a bad mood. The moment she walked in the door, he yelled at her to clean the mess in the kitchen. She yelled back at him to clean it himself as she did not make any of the mess. Her father then called her a "fat, lazy, ungrateful child" after which she ran up to her room and slammed her door. She did not come out of her room for dinner when her mother called her, and isolated herself in her room for the evening. Her father's words, "fat" and "lazy" repeated in her mind all evening, causing her to feel worse and worse about her life and her body. Starting at 8:00 pm, she stood looking at her body in a full-body size mirror for what she thought was about half an hour. She wore only her underwear to look at her body, and thought she needed to lose about 80 pounds to look decent. She felt ashamed of how she looked, and very depressed. By 9:15, she was hungry because she did not eat dinner, so she quickly gobbled down a chocolate bar that was in her backpack. Immediately after, she felt even more ashamed of herself and began to sob uncontrollably. She opened her dresser drawer where she stored a razor blade. She cut herself on her abdomen five times with the

razor, and experienced temporary relief from the shame and sadness. Soon after, she fell asleep. She has not spoken to her father since Tuesday.

This chain analysis is a detailed description of the events that led up to the cutting, and what happened after. As the client and counsellor discuss the events that occurred before the cutting, the client becomes familiar with patterns and warning signs of emotional or behavioural events that may precipitate cutting in the future. They also discuss skills to prevent self-cutting through the alternative solution analysis. The goals with this chain analysis are: (1) for the client to see the associations between events, emotions, and the self-harm; and (2) to develop effective behaviour skills to prevent herself from needing to cut in the future.

The counsellor and client may work on emotion regulation skills to alleviate feelings of shame, or sadness, and to increase self-esteem. They will review mindfulness skills so the client is able to stay in the moment and be aware of wise mind solutions that are available to her. They will also work on distress tolerance skills so she is better able to work through difficult moments without moving into crisis or using self-harm to deal with her feelings. A review of skills available and the importance of documenting their use on the Diary Card will be covered as well.

A DBT chain analysis is different from a cognitive behaviour therapy behavioral analysis. A behaviour analysis is broad, and looks at patterns of behaviour and the variables that affect them. A chain analysis is much more specific, as each chain analysis considers only one target behaviour. Each link in the chain focuses on a tiny change in emotion, thought, behaviour, or environmental stimuli before, during, and after the target behaviour. A

behaviour analysis helps to find *patterns* in behaviour, while a chain analysis is a detailed evaluation of a *single* chain of behavior (Chapman et al., 2006).

Dialectics. In DBT, dialectics is both a philosophical world view, and a counselling strategy. As a philosophical world view, the client is taught to see that there are opposing ideas for every stance taken. The client learns that some conflicts can be avoided or resolved by understanding that there can be more than one point of view, and that opposite opinions can both be right in their own way. As a counselling strategy, dialectics is important for bringing about change by helping the client to find the balance between opposite wants, needs, or ideas. Dialectics is also used when balancing counselling strategies such as acceptance and change strategies. If acceptance is used too much by the counsellor, the client feels no need for change. If change strategies are used too much, the client may feel too much pressure, while not feeling accepted or validated, and may drop out of counselling (Dimeff et al., 2001).

The counsellor will use the idea of dialectical communication to make movement in the clients' stance on how they feel about themselves. For example, a client who says, "I hate my life," does not hate everything about his or her life. The opposite position is, "*I like some of my life*." The counsellor will help the client to see that while the statement, "I hate my life," is true, the opposite position of, "I like some of my life," is also true. The client holds both opposing positions, and the pole can shift so that either statement becomes more or less true than the other. Change is constant. Dialectical change comes when the client realizes that both of these statements are true and that a small shift in the positive direction can make life

more worth living. Dimeff and Koerner (2007) maintain that "the constant refrain in DBT is that a better solution can be found" (p. 10).

There are additional dialectical strategies that the counsellor balances during therapy. The counsellor balances nurturance with challenge strategies. It is important to be nurturing when the client is vulnerable, yet to know when change can be attempted with a clear challenge. There also needs to be a balance between flexibility and stability. DBT moves quickly, so the counsellor must stay alert and flexible. Some change may occur through keeping the client on his or her toes by moving quickly enough so that the client does not know what to expect next. This needs to be balanced with stability so the counsellor gains the client's trust.

There are specific dialectical techniques used in DBT that all involve the balancing of opposites to promote change. The three most common dialectical techniques are: activating wise mind, devil's advocate, and extending. The activating wise mind technique involves the counsellor and client discussing the poles of emotional mind and rational mind to find a healthy balance of wise mind. The devil's advocate strategy is used to strengthen a client's commitment to counselling. The counsellor gives a ridiculous argument against committing which leads to the client arguing *for* commitment. With extending, the counsellor starts by communicating from the same point as the client, but then extends the communication and offers to act based on the extension (Chapman et al., 2006; Heard et al., 2000). For example, a client complains, "I've heard that clients you've had for longer than me can phone you whenever they need through the week instead of having to be scheduled like me. I want my phone calls to you to be whenever I want." At first, the counsellor communicates along the same line as the client by responding, "It is true that some of my clients eventually earn the

right to phone me when needed rather than being scheduled. Phoning in like that comes at a point when you are using your skills well and you have shown that you completely understand what the phone-in part of our counselling relationship is for." The client rolls her eyes dramatically and says, "If I can't call you whenever I want, I'll kill myself." Based on the last comment, the counsellor extends the communication. "If you feel like killing yourself now, how can I possibly discuss details of future phone consultations? Would you like me to arrange for you to be admitted to the hospital?" Through extension, the client is able to see that the response was extreme and it is necessary to backtrack.

An example of a skill taught in group which incorporates the idea of opposite is called *Opposite Action.* Opposite action is an emotion regulation skill. The client is taught to: (1) determine whether or not an emotion is justified by the situation, (2) be exposed to the trigger stimuli, (3) block the behaviour or emotional reaction to the stimuli, and (4) substitute an opposite behaviour. For example, a client is so anxious when she has to talk in front of her peers and boss during meetings that she has panic attacks, and runs out of the room. Her counsellor teaches her that anxiety brings up our fight or flight response. This response is useful when there is a real threat to ourselves, but when there is no threat of harm such as with speaking at a meeting, giving in to the flight response just reinforces the anxiety. Each time she runs out of a meeting, she is reinforcing the idea that she needs to be anxious, and therefore does not learn that the situation is in fact not threatening. The emotion and behaviour are not justified by the situation. The client will then repeatedly expose herself to staff meetings without having panic attacks by attending but not speaking. Exposure to the meetings without fear helps her to learn that there is no threat. She then works on substituting

opposite behaviour. She makes a brief comment at the next few meetings with her escape route blocked, and works her way up to being able to speak freely with no anxiety.

Opposite behaviour in opposite action can involve several things. Opposite behaviour might be as simple as making an opposite facial expression from what would normally happen after a given stimulus. An opposite behaviour might be holding a very different body posture, or making different movements. When the opposite behaviour practiced incorporates opposite thoughts, movement, posture, and facial expression, it is called *all-the-way-opposite-action* (Chapman et al., 2006).

Validation and acceptance. Validation is an acceptance strategy used to promote positive change. Validation or acceptance of the client is communicated through listening, reflecting, and summarizing key points from a session. The counsellor is constantly balancing validation with encouragement of change. The main purpose of validation is to help clients feel heard and understood. Validation communicates acceptance of the client in the moment, understanding or empathy for why the client felt or acted the way they did, and that there was some degree of truth or wisdom in the client's response (Balestri, Belfi & Sneed, 2003; Dimeff et al., 2001; Heard et al., 2000). It is important to remember that while validation communicates acceptance, "validation does not mean agreeing with everything or validating the invalid" (Glinski, Indik, Miller, Mitchell & Woodberry, 2002a, p. 576).

When used in DBT, there are six levels of validation; the first four are common to other forms of counselling. Level One Validation is called *listening and observing*, and is when the counsellor listens nonjudgmentally without attempting to change the person in the present moment. There is no verbal reflection at this point, but through body language the

counsellor communicates an interest in the client's feelings, thoughts and experiences. Level Two Validation is called *accurate reflection.* At Level Two Validation, the counsellor verbally communicates an accurate understanding of client feelings, thoughts, and experiences through reflection. Level Three Validation is called *articulating the unverbalized,* or *interpretation.* At this level, the counsellor goes beyond Level Two by stating the unsaid to show understanding of aspects of the behaviour that have not been directly spoken about. For example, after reflecting the experience of being called fat and lazy, the counsellor might reflect the unstated client feeling by stating, "You were hurt by that statement, sad, and possibly even a little angry about it." Level Four Validation is called *validating in terms of past events,* or *causes of behaviour.* This level of validation requires an understanding of the history of the client. The counsellor considers current behaviours and links them to past events or patterns of behaviour. Level Five Validation is called *validation in terms of current circumstances*, and is the level at which a DBT counsellor tries to consistently work. This level involves finding the truth in the opinion, feeling, or behaviour for the current context, and communicating that the response, or emotion served a function in that given moment. At this level, the counsellor links the behaviour or feeling to life history, but also points out that the emotion, opinion, or behaviour needs to be changed. For example, "I can understand why you push men away given that your past two husbands were physically abusive, but when you threaten to hurt yourself to keep a new man, it doesn't really work towards making you happy." Level Six Validation is called *radical genuineness*. When speaking with radical genuineness, the counsellor sounds the same as if speaking to his or her own upset sibling. When being radically genuine, the counsellor is direct with recommendations and feedback, and the client feels respected, and equal to the counsellor.

The client feels that he or she has a real capability to change (Balestri et al., 2003; Glinski et al., 2002a; Heard et al., 2000).

Stylistic communication strategies. The DBT counsellor utilizes two opposite communication styles. One style is deadpan and matter-of-fact, while the other is warm and empathetic. The matter-of-fact style is used to challenge the client, and cause the client to stop and think about what was just said. This style is used when change is desired and the counsellor wants the client to explore alternate options other than the one that was just stated. For example, if the client states, "If things don't change, I'll just start to scream and I won't stop." The counsellor will state, "So just scream." This will cause the client to stop and think, because screaming for the rest of his or her life is not realistic. The client may now be willing to think about alternate options realistically. Once the client starts really communicating about feelings and options, the counsellor will switch over to being warm and empathetic in order to validate the client's emotional pain (Heard et al., 2000).

Counsellor Characteristics

An important characteristic of a DBT counsellor is flexibility in order to work in a dialectical manner. The counsellor constantly moves between poles to find a balance that works for the client. For example, the message of acceptance in the moment must be balanced with challenge to change. An effective DBT counsellor is tough when necessary to push the client towards change, and can still be supportive through this difficult process. The counsellor is constantly in-tune with the client to stay flexible in the moment so that each session works for the individual client.

An effective DBT counsellor is skillful and nonjudgmental. The counsellor must be able to move quickly to keep the client on his or her toes. The counsellor must be well skilled in DBT methods to be able to move through the model based on the client's needs. The counsellor must be practiced in the art of validation to have an orientation towards acceptance. It is imperative that the client feel heard, understood, and accepted in the moment, even if the behaviours used have been socially maladaptive. It is important to be able to find some positive in any moment without blame; therefore, the counsellor must have a nonjudgmental attitude, and the ability to model grey, rather than all-or-nothing thinking. The counsellor must be skilled to know when to self-disclose and further develop the counsellor-client relationship.

Effective DBT counsellors are nurturing and compassionate, yet assertive. The counsellor helps the client to change through coaching, practice, and teaching of skills. They are able to develop compassionate counsellor-client relationships that show honest caring for clients. At the same time, the counsellor has well-developed assertiveness skills. For example, a counsellor does not shy away from a client's self-harm behaviour, but instead stays calm and centered. If a client refuses to speak, the assertive counsellor goes ahead with the session, and continues to ask questions (Talkes & Tennant, 2004).

Efficacy of Dialectical Behaviour Therapy

According to Dimeff and Koerner (2007), DBT demonstrates efficacy for reducing suicidal behavior among chronically suicidal clients with BPD, and a few other groups. When their book was published, there were nine published randomized controlled trials which had been conducted across five research institutions that supported the efficacy of

DBT. The trials found DBT to be successful with suicidal thoughts, self-harm behaviours, substance abuse, bulimia, binge eating, and depression. Other trials found DBT to be effective in forensic settings, with attention deficit-hyperactivity disorder, family violence, and adolescents (Brassington & Krawitz, 2006).

The first controlled trial of DBT was conducted by Linehan and her colleagues with 44 female clients with BPD. The women were evenly divided into two groups, and randomly assigned to DBT or TAU. All clients were assessed prior to treatment. Counselling took place for one year with clients being assessed again at 4, 8, 12, 18, and 24 months. DBT clients reported less episodes of self-harm, less anger, and had fewer psychiatric in-patient days than the TAU group. The DBT group had a total of 8.46 days in the hospital in the year, while the TAU group had 38.86 days in the hospital. DBT includes group, individual counselling, and team consult meetings that gave the TAU counselling group a smaller total of treatment hours. DBT counselling included more hours than TAU, but due to the decrease of in-patient hospital days for the DBT group, DBT counselling was less expensive than TAU. There were significantly less client drop-outs with the DBT group. At the one year mark, 16.7% of the clients had dropped out of the DBT group, while 50% had dropped out of the TAU group. Improvement in the DBT group continued in the year following counselling. The DBT group continued to have higher work performance, better self-reported social adjustment, less self-harm, and fewer hospital in-patient days (Heard et al., 2000).

Brassington and Krawitz (2006) reported on a trial of DBT with BPD clients in New Zealand. Following treatment, the DBT clients showed significantly less BPD symptoms. The DBT group showed a decrease in depression, paranoia, avoidance, self-harm, and anxiety. Psychiatric hospitalization stays decreased from 0.57 days per patient per month, to

0.2 days per patient per month. Brassington and Krawitz concluded that DBT is clinically effective, and they recommended that DBT be implemented into public mental health programs in New Zealand.

Miller and Rathus (2002) reported on a controlled trial of DBT with suicidal adolescents suffering from borderline personality features. The DBT group had significantly fewer psychiatric hospitalizations, and a lower rate of drop out than the TAU group. In the year following treatment, the DBT group had less suicidal thoughts, less psychiatric symptoms, and fewer BPD symptoms than the TAU group. The conclusion of this article was that "DBT appears to be a promising treatment for suicidal adolescents with borderline personality characteristics" (Miller & Rathus, 2002, p. 146). In another study investigating clients who inflict self harm, Duggan et al. (2001) concluded that DBT decreased self-harm, suicidal ideation, and depressive symptoms.

Comtois et al. (1999) reported on a study of DBT used with drug-dependent women with BPD. Subjects were randomly assigned to TAU or DBT for one year, and were assessed at 4, 8, 12, and 16 months. The DBT group had significantly greater reductions in drug abuse than the TAU group throughout counselling, and following treatment. The DBT group had less drop outs than the TAU group. Comtois et al. concluded that DBT is more effective than TAU in treating drug abuse with a BPD client.

Agras, Linehan and Telch (2001) reported on a study of DBT used with 44 women with Binge Eating Disorder. Their study showed DBT to be effective with this group. The DBT group showed improvements in weight concerns, shape concerns, and eating concerns. In fact, 89% of those in the DBT group did not binge eat any longer after completing DBT

treatment. Agras et al. hypothesized that DBT worked for these women by teaching them to control their urges and actions.

Barkham et al. (2003) reported on a trial examining the effectiveness of DBT used with male clients in a high security psychiatric hospital. The target behaviours for the program were anger, and violence. When compared to the TAU group, the DBT clients displayed reduced seriousness of violence-related incidents. The DBT group had lower levels of hostility, and anger. They concluded that DBT was more effective than TAU. DBT improves violent behaviour, and decreases anger of male forensic clients.

DBT is a relatively new counselling theory, therefore, limited research results as to its efficacy have been conducted to date. Although the therapy was originally devised for female clients with BPD, DBT is demonstrating efficacy for several other client populations. DBT has been shown to be effective for reducing suicidal behavior among chronically suicidal clients with BPD. The therapy was successful in reduction of suicidal thoughts, depression, and self-harm behaviours. DBT has also been proven to be effective for use with clients with substance abuse, bulimia and binge eating, attention deficit-hyperactivity disorder, and family violence. DBT has proven its efficacy in different settings (e.g., outpatient, inpatient, forensic) as well as in other countries. Because of these considerations, I suggest that DBT may be similarly effective for treatment of clients with LTLE.

Chapter Five: Using Dialectical Behaviour Therapy as an Approach to Left Temporal Lobe Epilepsy

The discussion in Chapter Five centers on the recommendation of DBT as a treatment for the psychological symptoms of LTLE. Because DBT has been shown to be effective for the aforementioned psychological problems, I suggest that DBT may be equally effective for clients with LTLE. First, I discuss the literature regarding the use of counselling for the treatment of LTLE. Next, I discuss the use of DBT for LTLE clientele, including a discussion of the inclusion of family members in counselling sessions. Finally, I revisit the questions raised in Chapter One.

Literature Regarding Counselling for Left Temporal Lobe Epilepsy

There is a gap in the literature concerning counselling for LTLE clients. Most of the authors of the journal articles found did not mention counselling, while the few that did were very brief. Andelman et al. (2001) simply stated, "Appropriate patient counselling is advised" (p. 549) but did not say what appropriate counselling was, or what theory counsellors should follow. Later in the article they state, "The increased level of anxiety frequently associated with left hemisphere lesions can be quite incapacitating… These patients are often in need of psychological counselling and psychotherapy" (p. 550). Once again, there is no guidance given as to what counsellors should do for these clients. Avanzini and Giovagnoli (2000) suggest specific memory training to attempt to improve the daily life for clients with LTLE. How to go about this training is not stated in the article. Beyenburg et al. (2005) state, "50 or 60% of patients with chronic epilepsy have various mood disorders including depression and anxiety" (p. 161). With such a high percentage of the population of

clients with LTLE suffering from mood disorders, it is essential that research on the efficacy of counselling be conducted.

Treating Left Temporal Lobe Epilepsy with Dialectical Behaviour Therapy

Studies have demonstrated the efficacy of DBT with the symptoms of BPD; due to the similarity of many of the psychological symptoms of LTLE, counsellors should have success teaching the skills of DBT to LTLE clientele. Efficacy has been demonstrated with suicidal behaviour and thoughts, self-harm behaviours, substance abuse, depression, and anxiety (Brassington & Krawitz, 2006; Dimeff & Koerner, 2007). Brassington and Krawit's research supports the use of DBT with adolescent LTLE clientele, as they found DBT to be effective with this age group.

As LTLE is a life-long diagnosis, it is important to find a counselling approach that will provide long-term help. The approach chosen must demonstrate efficacy beyond the counselling period. Heard et al. (2000) found 33.3% less client drop out in the DBT group than with TAU, and improvement continued for the DBT group in the year following including higher work performance, and better social adjustment. DBT shows promise as an approach to LTLE because it has been shown to reduce in-patient hospital days with BPD clients. Many LTLE clients spend time on an in-patient basis due to the psychological symptoms of their diagnosis. Heard et al. (2000) concluded that despite there being a large total of overall client hours with DBT, the reduction to in-patient hospital days caused DBT to be less expensive than TAU.

DBT was originally developed by Marsha Linehan as a treatment for women with BPD which has many symptoms in common with LTLE. Both client groups suffer from intense emotional spikes and from emotional disregulation. Both groups are emotionally sensitive, and therefore, find it difficult to be in control of their emotions. For example, clients may display irritability, or difficulty controlling anger. Both client groups have anxiety symptoms such as panic attacks, social anxiety disorder, obsessive-compulsive symptoms, generalized anxiety disorder, and depression. Suicidal symptoms are the main focus of DBT, and as stated previously in this project, suicide is the most common cause of death for LTLE sufferers. Both groups suffer from behavioural disregulation, and impulsive behaviours such as excessive spending, and substance abuse. Both groups have difficulties with self-esteem, communication, and with maintaining healthy relationships (Dimeff et al., 2001; Heard et al., 2000). As the symptoms of BPD that are treated with DBT are similar to the psychological symptoms of LTLE, I suggest that counsellors may have success using DBT with LTLE clients.

Chapman et al. (2006) made a good point in support of the use of DBT with clients suffering from disorders that affect the emotions. They stated,

> DBT treats the whole patient, rather than a discrete disease or disorder. Similarly, the whole emotion system is targeted in treatment, with the recognition that all elements of the system are interrelated, influencing both the patient's behavior and the environmental context external to the patient (p. 462).

DBT does not target BPD. The target during counselling is the emotional system of the client. Cooperatively, counsellor and client make a list of target behaviours and emotions on

which to work. The skills of DBT were created to target BPD symptoms. Because several of these symptoms are the same for LTLE and BPD, I suggest that the skills learned with DBT will be of great benefit to the LTLE client. As Chapman et al. stated, the client and others in the client's environment will be influenced by the learning of DBT skills.

The learning of DBT's skills will work for LTLE clients in the same way as they work for BPD clients. Change is brought about with mindfulness, opposite action, and chain analysis through identification of unwarranted emotional responses, exposure, response prevention and extinction. LTLE or BPD clients can learn more functional responses to emotional stimuli in their lives through mindfulness, dialectics, validation, opposite action, behavioural targeting, and chain analysis. The main function of DBT is to help the client live a functional life in the face of intense emotions (Chapman et al., 2006). For example, when a client has just been through a seizure which included the feelings of panic attack and extreme fear, this client can be taught to use crisis tools such as:

IMPROVE the moment:

- *Imagery:* This can be used to distract or soothe following the seizure. Imagery is created in the mind to distract from the fear that was felt during the seizure. In a way, it is like letting the mind go someplace more pleasant so the body can relax.
- *Meaning:* If the client is religious, this is a time to find meaning for their suffering. The client reminds him or herself that there is a higher purpose and eventually this suffering will be understood.
- *Prayer:* Open up to the moment and let it go. This does not mean that the client begs to have the suffering removed, the suffering is accepted and let go.

- ***Relaxation:*** Work on changing how the body responds to stress and fear. Relax the body to get through the stress, fear, and crisis faster. If this is difficult, the client will work on progressive muscle relaxation that will have been practiced in group counselling, and with the individual counsellor.
- ***One thing at a time to focus on:*** Focusing on one thing at a time helps the client get through the fear moment by calming the body and mind. The client learns to keep the focus that the next moment does not matter, it is simply this moment that has to be endured now. Breathe, and get through the moment as it is here before moving on to the following moment. It is important for the client to let go of what happened prior to, and during the fear caused by the seizure and to focus on what will happen next. The only thing that is important is the moment.
- *Vacation within your thoughts:* Clients have to let go sometimes and let someone else take care of themselves for a short piece of time.
- ***Encouragement:*** Clients will cheerlead for themselves and talk to themselves in such a way that they would like someone else to give encouragement in the moment.

The client will learn to choose one of these strategies to self-soothe following seizure events rather than holding on to negative thoughts about the panic, fear, or about the disability in general.

The skills of DBT can help during and immediately following a seizure. For example, a client, Sally, completely forgets the skills she has been working on. She is out shopping with her sister when Sally feels a seizure coming on. Her first pre-seizure indicator is a feeling that the ceiling seems to be getting closer to her and that the walls are closing in. She starts to breathe faster, and her heart beats faster as a panic attack begins. She can smell

burning toast and turns to say something to her sister, but realizes that she cannot speak. She stands in one spot for a minute, aware that she is in a seizure state. She repeatedly moves her right arm and chews her lip, feeling an all-encompassing panic attack. Once the seizure is over, she turns to her sister, says, "I have to get out of here," and quickly leaves the store without checking to see if her sister is following or not.

The same shopping trip with DBT skills in use would end differently. At the moment of noticing the sensation of the ceiling moving closer, Sally turns to her sister and says, "I may be having a seizure." She thinks about coping in a situation that cannot be changed and becomes mindful of her breathing and heartbeat to stay in control as much as possible rather than giving in to the panic attack. Eventually, the seizure is over and Sally has stayed in control of her breathing with the help of staying mindful the entire time. This has held back the panic attack. After a brief rest at the food court, Sally is ready to get back to shopping with her sister. DBT skills have helped to keep her in control.

Inclusion of Family Members

When the LTLE client is an adolescent or has a spouse, family can be included in the skills training group. Inclusion of family members is a modification from original DBT. Glinski et al. (2002a) clearly described the advantage of including family when they stated, "Family members' participation in the skills training group enables them to learn skills so they can not only behave more skillfully themselves but also become models and coaches for their adolescents" (p. 569). For example, if the client is a 16-year old boy, he might come to group with his mother and father. When all three family members learn the skills of DBT, the parents can help their son to use these new skills when a difficult moment occurs. They can

also practice these skills as a family during conflict. The family will be taught the idea of conflict and dialectical philosophy. The understanding and practice of mindfulness and dialectics will decrease the intensity of conflict as family members realize that the opposite positions of others can be right at the same time. As a family, individuals learn to listen without judgment to the opinions of other family members.

Family members learn how their own behaviours during interactions with the client can contribute to client problem behaviour. Strategies such as chain analysis can be used to show how all family members affect each other. The procedures of chain analysis would be taught in the first half of a group session. The idea of chain analysis can be shown at the beginning of a session through role play. One of the co-counsellors would purposely be late for the session and would be asked by the other counsellor to do a chain on the board to explain to everyone in the room why he or she was late for group. This illustration shows the group how each small thing that the counsellor was thinking or doing had an effect on the lateness. In the second half of group, families will be asked to think of something that recently happened for which they all agree to try a chain analysis. While family members discuss what happened, the co-counsellors circulate to facilitate. As a family chain analysis is made, individual members realize how their emotions, thoughts, and actions affect others in the family, both positively and negatively. Through the analysis process, family members begin to learn how they contribute to or reinforce the target client's problem behaviour, and then agree to make positive change. With chain analysis, families can see where they have been working well together, and where they have patterns of behaviour that are not positive. Family relationships can be a source of strength, coaching, and change.

Glinski et al. (2002b) wrote about including family members in multifamily group skills training. These multifamily groups have been conducted as a component of DBT with both adult and adolescent clients. The main goal for the inclusion of family in a DBT group is to increase the client's skills in real life situations through reinforcement of skills by family members. Glinski et al. concluded, "The multifamily group format can also promote increased dialectical thinking, emotion regulation, interpersonal effectiveness, and mutual or cross-validation" (p. 590). Dialectical thinking and interpersonal effectiveness can be practiced with family members during the second half of group sessions. Family members learn to validate each other, and as families learn through group that other families have similar communicational difficulties, family members begin to validate the feelings and experiences of other families.

Questions Revisited

1. DBT skills are presented in four modules. Would these modules be of benefit to a client with a diagnosis of LTLE?

The skills learned during these four modules were created to target the symptoms of BPD. As many of these symptoms are the same as a client with LTLE can experience, the modules should benefit LTLE clients. These modules will help clients with skills to communicate more effectively while maintaining self-esteem. The skills will help to reduce suicidal or self-harm ideation, and to help to get through difficult moments without crisis. For example, the client will learn how to work effectively through a panic attack. The modules will help the client increase positive emotions and to regulate other emotions more effectively. Typical fears for the LTLE client might be around memory loss with aging, and

with problems around personal relationships. The skills learned in these modules will help the client to find new ways to cope with fears and anxiety. These modules will also help clients to stay in the moment with mindfulness skills rather than ruminating on past problems or on future fears of what LTLE will bring for them as they age.

As many of the psychological symptoms of LTLE are biologically based, it can be difficult for the client to control symptoms during a seizure. The skills of DBT would be most useful for this client when not in a seizure state. Due to this fact, it is possible that an LTLE group will benefit from more weeks with the first module of Core Mindfulness Skills rather than the month devoted with the Linehan model. Core Mindfulness is revisited with each following module. The LTLE client may need reinforcement of the idea that many of the symptoms are caused by brain action, therefore regardless of how much DBT skills are practiced, the seizures will not go away. Mindfulness will help clients get through each moment, while keeping in mind that when the seizures end, things will be different. The LTLE client may have difficulty with interpersonal effectiveness skills, therefore, a longer period of time, and more practice with this skill module may be needed. More practice and examples will allow for a full exploration of the client's personal barriers to the use of these skills.

2. DBT skills modules were written for women with borderline personality disorder. Would the worksheets and module handouts have to be modified for LTLE clientele, for men, or for different age groups before they could be used?

After reading through Marsha Linehan's group materials, it is my opinion that many of these materials are useable as they are for the LTLE client because many of the

psychological symptoms of LTLE are the same as BPD. Some worksheets and handouts should be re-written, modified, or extra worksheets written to take into account that LTLE clients can be men or adolescents. For example, self-soothing ideas could include watching a football game, or going on a long bike ride rather than Linehan's classic ideas such as taking a bubble bath or gardening. Bubble baths and gardening will likely not appeal to the adolescent or male client. As the LTLE client often has difficulty communicating with family members, offering group counselling to family members would also be beneficial. In this case, worksheets can be modified to apply to family situations.

3. The emotional, communicational, interpersonal, and psychological aspects of a diagnosis of LTLE can increase with stress. Therefore, can DBT help the LTLE client by helping to manage stress?

DBT will help the LTLE client through stress management. Mindfulness work is a form of meditation that has been shown to be very effective in stress reduction (Kabat-Zinn, Segal, Teasdale & Williams, 2007). Module work around interpersonal effectiveness will reduce stress with communicational and self-esteem difficulties. The module for emotion regulation will greatly help reducing stress as the client learns to increase and focus on positive emotions. The final module about distress tolerance will be of assistance as the client will learn to tolerate unchangeable stress in the moment, and then leave that stress there, in the past, where it belongs. The LTLE client will be able to deal with stressful situations with skills that enable him or her to try new behavioural reactions that will create a life more worth living. There is a great deal of anxiety around disclosure of LTLE with friends, at

work, and in relationships. It is possible that work with stress reduction and anxiety could make disclosure of LTLE a lesser source of anxiety.

4. Will DBT be an effective strategy to use with LTLE clientele?

I believe that DBT will be effective with LTLE clientele. The counsellor may be successful with the LTLE client due to the similarity between symptoms of LTLE and BPD. Similar symptoms include: anxiety, depression, suicidal ideation, communication difficulties, and relationship problems. Helping the client to stay in the moment, rather than focusing on past or future seizures can increase the positive emotions experienced, and make life more worthwhile.

LTLE symptoms can be worked on during individual sessions; symptoms treated might include anxiety, depression, suicidal ideation, communication difficulties, and relationship problems. An example of LTLE anxiety that can be worked on in counselling is around the fear that the symptoms could get worse. This idea will especially be a focus when medications are being adjusted or changed. Depressive thoughts should be worked on continuously to be sure the client is not stuck in depressive thinking patterns such as, "I'm so unhealthy," or "I can never remember anything!"

The relaxing skills taught in distress tolerance are called self-soothing skills. LTLE clients will benefit from being taught to soothe themselves before facing situations to give them the strength to deal with possible overwhelming feelings of anxiety. When a situation is faced after self soothing, the client is better able to figure out what to do next. Clients are taught many ways to soothe themselves through the senses. LTLE clients will benefit from

being taught how to create a personal relaxation plan so they can self soothe in any environment.

Counsellors need to be aware of communication and relational difficulties that need work for their clients. Clients may fear that as memory problems get worse with age, their marriages may break up. They may be having financial problems in their marriages due to the costs of medications or medical procedures. Through DBT skills training, the counsellor helps the client to make life the best it can be in the moment.

Chapter Six: Recommendations and Conclusions

I believe, firstly, that this paper will contribute an interesting and new perspective to the research field. Furthermore I hope to stimulate research in the relationship between effective counselling practice such as the use of DBT and treatment of LTLE. I discuss both issues below and provide concluding remarks.

LTLE is a medical condition for which a counsellor can provide assistance due to the many psychological symptoms of the diagnosis. The quality of life for clients suffering through the symptoms of LTLE can be improved with the assistance of a counsellor; therefore, it is important that information regarding the symptoms of LTLE and academic research regarding counselling theory and strategies which may help this clientele be available to people in the helping professions. Counsellors may find success when using DBT with the LTLE client due to the similarities between the psychological symptoms of LTLE and the symptoms of BPD.

The recommendations that arose as this project was researched were in the areas of practice and theory. The theory recommendations will be discussed first, while finer details of practice with this clientele will be presented second. Due to the large number of psychological symptoms for LTLE clients, it is essential that research about appropriate and effective counselling theory for this client group be conducted. This gap in the literature needs to be addressed through academic research in the area of counselling theory. Research must be conducted which tests the efficacy of DBT for LTLE clients.

DBT is a relatively long-term therapy, as it demands a one-year commitment. It is also a relatively new treatment as it has only been available since 1993. Several longitudinal studies utilizing DBT conducted by different teams of researchers would be helpful to

identify the number of clients who continue to use the skills learned in a year or two years following counselling.

When writing about counselling and LTLE, Beyenburg et al. (2005) stated, "there are no systematic treatment studies or evidence-based guidelines for best treatment practice" (p. 161). Rather than studies comparing DBT to TAU, studies comparing DBT to CBT should be conducted. These studies would examine the usefulness of DBT skills, over and above traditional CBT methods.

In terms of practice with the LTLE client, a theory such as DBT must be chosen due to the many psychological difficulties that the client may be enduring, and the skills training used in DBT. DBT's distress tolerance skills may help with depression, anxiety, obsessive compulsive behaviours, and suicidal ideation. "While we can't always control the pain in our lives, we can control the amount of suffering we have in response to that pain" (Brantley et al., 2007, p. 9). Research into the usefulness of the teaching of distress tolerance skills to help the LTLE client distract and relax him or herself, and to cope is needed. This research will show whether of not the LTLE client's quality of life improves after being taught to give time for emotions to settle after a seizure. After being taught to distract their thoughts, to distract by leaving a situation, to distract by doing something else, or through creating a personal distraction plan, is the LTLE client better able to tolerate distress?

Research into the usefulness of DBT's emotion regulation skills with LTLE clients is needed. These skills should teach the LTLE client about hard to control emotions, depression, anxiety, obsessive compulsive behaviours, and difficulties with relationships. As these are all difficulties that continue between seizures, research should show that teaching LTLE clients emotion regulation skills helps the client in the areas of recognizing emotions,

overcoming barriers to healthy emotions, increasing positive emotions, and to problem solving more effectively.

Research into the effectiveness of DBT's interpersonal effectiveness skills is needed. LTLE clients may deal with difficulties in interpersonal communication, and difficulties with relationships. Through DBT skills, the client is taught to pay mindful attention to the other person's verbal and physical behaviour during interactions. At the same time, the client must pay attention to his or her own needs and feelings in order to decide if any of these must be communicated. Important skills for LTLE clients to learn are those of knowing what they want, asking for what they want, negotiating conflicts, listening, and saying no in such a way that relationships stay intact. Research will show whether or not the LTLE client's personal relationships improve after completing and practicing this skill area.

Finally, Avanzini and Giovagnoli (2000) suggest specific memory training to improve the daily life for clients with LTLE. As memory issues are a concern for a large portion of the LTLE population, this is something that should not be overlooked. As the memory difficulties are due to scarring of the brain, and this is a degenerative condition, memory will get worse with time. The learning of strategies to remember names, directions, and medication schedules are very important. Psychiatrists working with LTLE clients should be researching and informing colleagues of useful memory strategies that work for this clientele.

Contribution to the Field

This project contributes to counselling literature by discussing the application of DBT with LTLE clientele. The project informs counsellors of the emotional, communicational,

relational, and psychological aspects of left temporal lobe epilepsy. There is an overview of DBT, including a discussion of efficacy with several different client groups. The project then provides a rationale for the effectiveness of DBT with LTLE clients. Examples of original teaching pages and worksheets for group modules are provided, including instructions for the counsellor. As the LTLE client can be any age group or sex, each worksheet has been prepared for teen, adult, or family groups to demonstrate how to modify worksheets. This project is only a start towards filling the gap that exists in the literature regarding the best theoretical stance to take when providing counselling to LTLE clients. More research is needed to assist this clientele.

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Appendix A: Use and Special Considerations for Appendices

The appendices contain original worksheets that can be used in a DBT group. DBT worksheets and homework materials provide clients, and counsellors, with a common and effective language for identifying needs, and developing the skills to make positive change. These worksheets are different from the original materials created by Marsha Linehan, as she created DBT to be used with adult women. LTLE clientele could be adolescents, women or men; therefore, the worksheets in the appendices have different language to appeal to different age groups, or sexes. Also, Linehan did not include worksheets on using dialectical thought. As dialectics is such an important aspect of DBT, I have created worksheets for this topic and inserted them in the appendices (Appendix C-F).

With the exception of Appendix B: Diary Card, each other appendix topic is arranged with the same format. The first two pages of the topic are teaching pages to be used in the first half of a group session to teach the skill to the group. The following three pages are worksheet pages to be used as skill learning or reinforcement during the second half of group, or for homework. During the second half of group, the two co-counsellors circulate to assist with skill understanding as worksheets are completed. As LTLE clientele can be adolescents or adults, separate worksheets have been provided for these groups as a demonstration of how to modify materials. The first worksheet page is a teen worksheet, and the second page is the same worksheet modified to be used with male or female adult groups. The final worksheet is modified to be used with a family group. When a family is in group, one family member works as a recorder, while all family members' ideas are written onto the worksheet.

Appendix B: Diary Card. A diary card will be created for each client. The target behaviours listed on the card are cooperatively identified by the counsellor and client. The counsellor should have a blank template of a diary card on a computer which can be quickly modified for individual clients as behaviours are targeted in the first few sessions. For example, one client may have target behaviours of sleep, anxiety, obsessions, and checking behaviours on the diary card. Another client may target the behaviours on the card as anger, physical violence, drinking, drug use and anxiety. Each client card will contain the amount of behaviours agreed upon by client and counsellor. There is no set amount of behaviours to target with DBT. Diary cards are used on a weekly basis to track frequency of behaviours and skills used, as well as events that might have contributed to the target behaviour (Wolpow, 2000).

The diary card created for Appendix B is for an imaginary LTLE client based on the psychological symptoms of LTLE. This client has difficulty regulating his sleep. He is depressed, and has suicidal thoughts. His targeted behaviours are around panic attack symptoms and communication difficulties with others. As this is an LTLE diary card, the symptoms could have included any of the following symptoms; depression (mood), suicidal or self-harm urges, generalized anxiety disorder symptoms (fatigue, difficulty concentrating, irritability, difficulty falling or staying asleep), panic attack, obsessive compulsive symptoms (repetitive thoughts or repetitive behaviours), or communication difficulties (easily irritated by others, verbal or physical conflict).

Appendix C-F: Dialectical Open-Minded Thinking. The worksheets for Dialectical Open-Minded Thinking are completely original to this project as Linehan did not create dialectical worksheets in her 1993 materials. Note that this is the only appendix which has an answer key for the worksheets as all other sheet sets are based on individual client experiences. The answers for the teen, adult and family worksheets are the same, so the answer key is the following; 1 c, 2 a, 3 b, 4 a, 5 c. During the first half of group, counsellors will give several examples of dialectical thinking and the importance of it. The worksheets are to be completed independently while counsellors circulate to answer any questions. Once the group has completed the work, questions are to be orally discussed to ensure understanding by the group.

Appendix G-J: Mindfulness. The first half of this group session will be spent with hands-on activities to practice mindfulness. When understanding is achieved with hands-on activities, worksheet activities can be completed during the second half of group. An effective way to have a client group practice being mindful is to take away the sense of sight. Before blindfolding the group, give them each a foil-wrapped candy and tell them to just eat it as they normally would at home. When done, ask them to put on blindfolds. When the group is blindfolded, hand out another of the same foil-wrapped candy into the palm of each client. Give the instruction to hold the candy and wait until everyone has one. Instruct the group to empty their minds of all other thoughts except for the candy, as they are going to practice being mindful of eating their candies. Ask them to unwrap the candy and listen to the sound that the wrapper makes as it unfolds at the ends and from around the candy. When it is unwrapped, feel the shape of the candy and then smell it. Take a long, slow smell of the

candy. When ready, place the candy on the tongue and slowly, mindfully taste it. Roll it around in your mouth being mindful of the shape, feel and flavour. Do not let anything else enter your mind. Instruct the room to be mindful of the candy with no other intrusive thoughts, with no talking in the room for one full minute. Be sure to debrief afterwards. Was there a difference between the mindful-candy and the first one?

Appendix K-N: Interpersonal Effectiveness. Prior to working on the worksheets for Interpersonal Effectiveness, clients must be taught the skills of DEAR MAN, GIVE, and FAST. DEAR MAN skills are used to get what you want out of a situation. First, the client will **D**escribe the situation. It is important to stick to the facts and not use judgemental statements. Next, the client will **E**xpress feelings or opinions about the conflict clearly. The next step is to **A**ssert wishes such as saying, "No" clearly. Remember to **R**einforce behaviour of people who respond positively when you ask for something. For example, "Thanks for being understanding. I appreciate this." Remember to be **M**indful about what you want. You may have to use the skills of *broken record* by repeating your request, or *ignoring* if the other person threatens. It is important to **A**ppear confident. When asking for something, you should not look down at the floor or talk in a very soft voice. Finally, you may have to **N**egotiate. To get what you want, you may have to give something.

GIVE skills are used when the relationship is of the highest importance; therefore above all, you want to keep the relationship. Be **G**entle during this interaction. Your approach will avoid attacks, threats and judgements. You will act **I**nterested in the other person's point of view. Do not interrupt while the person is speaking. Patiently wait and

listen. Be sure to **V**alidate the other person's feelings. Use an **E**asy manner throughout the conversation. Try to smile and help the other person to be comfortable.

FAST skills are used when it is most important that you preserve your self-respect. Firstly, it is important to be **F**air to yourself and the other person while trying to solve the conflict. Secondly, be aware of when to make **A**pologies. Only apologize when appropriate. Do not apologize for making a request, or for having an opinion. Always **S**tick to your values. Be clear about what you believe to be the moral thing, and stick to that. The final point is to be **T**ruthful.

Appendix O-R: Emotional Regulation. Prior to the worksheet for Emotion Regulation, discuss what challenge or cheerleading statements are. When a client has a worry about standing up for him or herself, or about expressing an opinion, this worry is sometimes based on a myth, or untruth. A challenge is when client and counsellor logically talk through a myth to show that the myth is untrue. The challenge counteracts the myth illustrating the client's unrealistic beliefs which are interfering with effective behaviour. Point out that clients need to watch out for the word 'should' which can not be used in challenge statements. "Cheerleading statements are statements that people make to themselves… in order to give themselves permission to ask for what they need or want, to say no, and to act effectively" (Linehan, 1993, p. 77). For example, a cheerleading statement might provide courage or prepare the client for the situation. In group, clients work on the worksheet independently and then share orally when complete. Whenever oral sharing occurs remind clients to write anything down that they may want to remember later. For example, with this

session, if a group member states a cheerleading statement that might be useful to an individual later, encourage group members to note this on the worksheet.

Appendix S-V: Distress Tolerance. Prior to the worksheet for Distress Tolerance, discuss how to use the strategy Pros and Cons to tolerate a difficult situation. A drama by the counsellors is a good idea to get the idea across. The top of the worksheet includes an example of a completed pro and con list for the urge to yell. When the worksheet is first handed out, the counsellors will read over the chart orally and discuss each point to ensure that group members understand how to use each quadrant of the chart. When it is clear that everyone knows how each quadrant works, clients will create their own pros and cons chart based on their own target behaviours and situations which cause distress.

Appendix B: Diary Card

Diary Card			Initials:					
	Time to sleep and time up		Severity of depression (0-5)	Self-harm urges (0-5)	#Self-harm actions	Irritated by others (0-5)	# Verbal conflicts	# Physical conflict
Mon								
Tues								
Wed								
Thurs								
Fri								
Sat								
Sun								

* USED SKILLS OR NOT:
0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried, but couldn't use skills
4 = Tried and used skills, but didn't help
5 = Tried and used skills, helped
6 = Used skills without trying, but didn't help
7 = Used skills without trying, helped

Skills Diary Card	Circle the days you worked on each skill.						
Wise Mind	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mindful: observe, just notice	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mindful: nonjudgmental stance	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mindful: in-the-moment	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Objective effectiveness: DEAR MAN	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Relationship effectiveness: GIVE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Self-respect effectiveness: FAST	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Reduce vulnerability: PLEASE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Build positive experiences	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Opposite action: opposite of emotion	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Distract	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Self-soothe	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Pros and cons	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Radical acceptance	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Adapted from Linehan (2003).

Appendix C: Information Sheets for Dialectical Open-Minded Thinking

Dialectical or Open-Minded Thinking: What is it?

Dialectical means: two ideas are true at the same time.

- All people's ideas are equally important, and they all have something to teach us.
- There is always more than one way to see a situation, opinion, idea, or thought.
- While two ideas are opposite, they can both be true.
- All points of view have two sides.
- Even one person can have two opinions about the same thing. This is a dialectical thought.
- For example:

  -I am doing the best I can. AND I need to try harder.

  -I can take care of myself. AND I need friends.

When you are using dialectical skills, you are:

- Using 'grey' thinking rather than 'all or none' thinking.
- Finding what is 'left out' of your understanding of a situation.
- Not blaming.
- Not making assumptions about what someone else is thinking.
- Listening to the points of view of others.
- Not arguing your point of view in a conflict situation.

Guidelines for Dialectical or Open-Minded Thinking

DO:

- Consider the middle ground rather than 'all or nothing' thinking.

  -Avoid extremes such as *always* and *never*.

  -Try to use 'both-and' thinking.

  -For example: "Everyone is always mean to me." Becomes…

  "Sometimes people are mean to me AND other times people are nice."

- Listen to the points of view of others.

  -Be willing to listen.

  -Remember that no one can own the truth.

  -For example: "You don't know what you are talking about." Becomes… "I can see your point of view, even though it is so different from mine."

DON'T:

- Assume that you know what someone else is thinking.

  -Ask, "What did you mean when you said that I was bothering you?"

- Expect others to know what you are thinking.

  -Be clear, "What I am trying to say is that I feel ignored when you go out with your friends every evening."

Appendix D: Teen Worksheet for Dialectical Open-Minded Thinking

Circle the letter of the dialectical statement for each group of sentences.

1. a. This sucks, and I give up.

   b. This is easy, and I have no problems.

   c. This is hard, and I am going to keep trying.

2. a. I can see it this way, and you see it that way.

   b. I am totally right, and it is true.

   c. I'm stupid, and you are right.

3. a. I'm always wrong, and everyone is always unfair to me.

   b. In some situations, I see that I'm not treated fairly.

   c. I'm always treated fairly.

4. a. Sometimes when I need to talk to someone I can talk to my teacher.

   b. My teachers should always listen to me whenever I need to talk.

   c. My teachers shouldn't ever have to listen to my problems.

5. a. All of my problems are my own fault.

   b. All of my problems are my parents' fault, so I shouldn't have to solve them.

   c. My parents have been the cause of some of my problems, but I still have to work to solve all of them.

Appendix E: Adult Worksheet for Dialectical Open-Minded Thinking

Circle the letter of the dialectical statement for each group of sentences.

1. a. I hate doing this, and I quit.

   b. This is easy, and I have no problems.

   c. This is difficult, and I am going to keep trying.

2. a. This is my opinion, and you see it differently.

   b. I am right, and it is true.

   c. I am always wrong, and everyone else is always right.

3. a. My spouse and / or friends are always unfair to me.

   b. In some situations, I see that I'm not treated fairly.

   c. I'm always treated fairly.

4. a. I trust some people, and I find it hard to trust others.

   b. I don't trust anyone because I always get hurt.

   c. I could trust everyone if I were really healthy.

5. a. All of my problems are my own fault.

   b. All of my problems are my spouse's fault, so I shouldn't have to solve them.

   c. Other people have been the cause of some of my problems, but I still have to work to solve all of them.

Appendix F: Family Worksheet for Dialectical Open-Minded Thinking

Circle the letter of the dialectical statement for each group of sentences.

1. a. Our problems are too big; we should give up.

   b. We are fine, and we have no problems.

   c. This is hard, and we will keep trying.

2. a. Parents see it this way, and kids see it that way.

   b. Parents are always right, and what they say is always true.

   c. Kids should always do what their parents say because they are always right.

3. a. As a family, we always treat each other unfairly.

   b. In some situations, we treat each other fairly.

   c. As a family, we always treat each other fairly.

4. a. Sometimes we can talk to each other about our feelings.

   b. We should always listen to each other when one of us needs to talk.

   c. We should never have to listen to each other's problems.

5. a. All of our problems are because of fighting.

   b. If you started the fight, you have to fix the problem because it is your fault.

   c. As a family, sometimes opposing wants and opinions cause conflicts.

Appendix G: Information Sheets for Mindfulness

Mindfulness: What is it?

Mindfulness means: taking control of your attention and thoughts to be in the moment.

Observe:

- Notice how you feel without trying to make feelings stronger or weaker.
- Pretend you are slippery; let experiences, thoughts and feelings come into your mind and then slide off of you.
- Control your attention, but not what you are seeing or experiencing. Just notice everything around you without changing it.
- Pay attention to all of your senses; sight, hearing, smell, touch, taste. Find something good in each of these senses right now.

Describe:

- Use words to describe what your senses are telling you.
- Use 'fact' words. Don't paint a colourful picture or magnify the situation. Describe it exactly as it is.
- Let go of your need to be right when describing. Describe without judgement.

Participate:

- Be involved in the moment and forget all other thoughts for the time being.
- Accept yourself and the situation for the good it has to offer you in this moment.

Guidelines for Mindful Thinking

DO:

- Use a non-judgmental stance.

  -See the facts, but don't evaluate. Focus on *what* your senses tell you.

  -Take your opinions out of the facts.

  -Accept each moment as it comes. There will always be change.

- Be one-mindful in the moment.

  -Do one thing at a time and give it all of your attention. If you are eating a candy; enjoy the flavour of it until it is gone.

  -If something distracts you from what you are focused on, go back to what you were doing again.

  -Concentrate on doing one thing at a time. If you find yourself working on, or thinking about two things at the same time, stop what you are doing. Concentrate, and start again.

DON'T:

- Evaluate.

  -Leave behind words: good, bad, terrible, should, or should not.

- Judge your judging.

  -When you find yourself judging something or someone, just let it go and move on. Don't judge yourself and get stuck.

- Let strong feelings, thoughts or actions distract you from being mindful.

Appendix H: Teen Worksheet for Mindfulness

Being Mindful by Observing and Describing Thoughts

Fully describe an event that happened in the past week which was difficult.

Describe what happened before, during and after the event.

Before:_____

_____

_____

During:_____

_____

_____

After:_____

_____

_____

Check any *feelings* the event brought up.

____irritated	____sad	____confused	____jealous
____grumpy	____lonely	____overwhelmed	____scared
____mad	____empty	other (specify) _____	

What were you *thinking*?

_____

_____

_____

_____

Can you think of any *must* statements that you believe about yourself? (I must…)

Can you think of any *should* statements that you believe about yourself? (I should…)

Can you think of any *must or should* statements about others? (He or she should have…)

Pick a *should* thought and change it to a non-judgemental statement.

Appendix I: Adult Worksheet for Mindfulness

Being Mindful by Observing and Describing Thoughts

Fully describe an event that happened in the past week which was difficult.

Describe the prompting event, what happened during and the consequences.

Before:_____

_____

_____

During:_____

_____

_____

After:_____

_____

_____

Check any *feelings* the event brought up.

____annoyed	____apprehensive	____terrified	____miserable
____angry	____anxious	____jealous	____frustrated
____spiteful	____afraid	other (specify) _____	

What were you *thinking*?

_____

_____

_____

_____

Can you think of any *must* statements that you believe about yourself? (I must…)

Can you think of any *should* statements that you believe about yourself? (I should…)

Can you think of any *must or should* statements about others? (He or she should…)

Pick a *should* thought and change it to a non-judgemental statement.

Appendix J: Family Worksheet for Mindfulness

Being Mindful by Observing and Describing Thoughts

Fully describe an event that happened in the past week which was difficult.

Describe what happened before, during and after the event. What part did each of you play?

Before:_____

_____

_____

During:_____

_____

_____

After:_____

_____

_____

Check any *feelings* the event brought up by initialling the space.

____disappointed	____frustrated	____angry	____humiliated
____disgusted	____smothered	____guilty	____jealous
____resentful	____worried	other (specify) _____	

What were each of you *thinking*?

_____

_____

_____

Are there any *must* statements that you believe about yourselves? (I must…)

Are there any *should* statements that you believe about yourselves? (I should…)

Can you think of any *must or should* statements about others?

Pick a *should* thought and change it to a non-judgemental statement.

Appendix K: Information Sheets for Interpersonal Effectiveness

Interpersonal effectiveness means: having self-respect and using effective communication skills that keep relationships healthy.

- Relationships that are not attended to can create stress that is difficult to repair. It is important to learn how to balance the demands in life and relationships, with your personal priorities.
- Priorities are things that are important to you.
- Demands are things that others want you to do, or from you.
- Sometimes priorities and demands conflict.

Goals of Interpersonal Effectiveness:

- Objectives Effectiveness: attaining your objectives in a situation.

  -Standing up for your rights.

  -Requesting things from others.

  -Refusing unreasonable or unwanted requests.

  -Resolving conflict with others.

- Relationship Effectiveness: getting or keeping good relationships.

  -Earning the respect of others.

  -Think about, "How do I want this person to think about me after this conversation is over? Do I want to keep this relationship?"

- Self-respect Effectiveness: liking yourself.

  -Act so you feel moral; respect your values and beliefs.

  -Think about, "What do I have to do in this interaction to respect myself when it is over?"

Guidelines for Interpersonal Effectiveness

Factors that Reduce Interpersonal Effectiveness:

- Lack of Skill.

  -You don't know what to say or how to act.

  -You don't know what will work to get what you want.

- Worry Thoughts.

  -You worry about consequences. "They won't like me. I might say something stupid."

  -You worry that you don't deserve to get what you want.

  -You call yourself names or worry about being ineffective. "I can't do it. I'll probably have a nervous break down. I'm such a loser."

- Emotions.

  -Anger, fear, guilt, or other emotions get in the way of your ability to act effectively.

  -You allow strong emotions to prevent you to say or do what you want.

- Indecision.

  -You can't decide on priorities so don't know what you want or what to do.

- Environment.

  -Something about your environment makes it impossible for you to be skilful. For example, someone is too critical, or someone wouldn't like you if you tried to get what you want.

Appendix L: Teen Worksheet for Interpersonal Effectiveness

Describe a conflict you had with someone this week. Who did what?

_____

_____

What results did you want in the situation?

_____

_____

How did you want the other person to feel about you?

_____

_____

How did you want to feel about yourself?

_____

_____

What skills did you try to use? (Check below)

FAST (Keeping respect for myself)

____ **F**air

____ **A**pologies (no excessive apology making)

____ **S**tuck to values

____ **T**ruthful

DEARMAN (Getting what you want)

____ **D**escribed situation

____ **E**xpressed feelings / opinions

____ **A**sserted

____ **R**einforced

____ **M**indful

____ Broken Record

____ Ignored

____ **A**ppeared confident

____ **N**egotiated

GIVE (Keeping the relationship)

____ **G**entle

____No threats

____ No attacks

____ No judgements

____ **I**nterested

____ **V**alidated

____ **E**asy Manner

What reduced your effectiveness in the conflict? (check)

____ Lacking skills ____ Worry thoughts

____ Emotions ____ Indecision

____ Other describe: _____

_____

_____

Appendix M: Adult Worksheet for Interpersonal Effectiveness

Describe a conflict you had with someone this week. Who did what?

_____

_____

What were your objectives in the situation? (What results did you want?)

_____

_____

What was the relationship issue? (How did you want the other person to feel about you?)

_____

_____

What was the self-respect issue? (How did you want to feel about yourself?)

_____

_____

What skills did you try to use? (Check below)

FAST (Keeping respect for myself)

____ **F**air

____ **A**pologies (no excessive apology making)

____ **S**tuck to values

____ **T**ruthful

DEARMAN (Getting what you want)

____ **D**escribed situation

____ **E**xpressed feelings / opinions

____ **A**sserted

____ **R**einforced

____ **M**indful

- ____ Broken Record
- ____ Ignored

____ **A**ppeared confident

____ **N**egotiated

GIVE (Keeping the relationship)

____ **G**entle

- ____No threats
- ____ No attacks
- ____ No judgements

____ **I**nterested

____ **V**alidated

____ **E**asy Manner

What reduced your effectiveness in the conflict? (check)

____ Lacking skills ____ Worry thoughts

____ Emotions ____ Indecision

____ Other describe: _____

_____

_____

Appendix N: Family Worksheet for Interpersonal Effectiveness

Describe a conflict within your family this week. Who did what?

_____

_____

_____

What was each of your objectives in the situation? (What results did you want?)

_____

_____

_____

What were the relationship issues? (How did each of you want others to feel about you?)

_____

_____

_____

What were the self-respect issues? (How did each of you want to feel about yourselves?)

_____

_____

_____

What skills did each of you try to use? (Initial below)

FAST (Keeping respect for myself)

____ **F**air

____ **A**pologies (no excessive apology making)

____ **S**tuck to values

____ **T**ruthful

DEARMAN (Getting what you want)

____ **D**escribed situation

____ **E**xpressed feelings / opinions

____ **A**sserted

____ **R**einforced

____ **M**indful

____ Broken Record

____ Ignored

____ **A**ppeared confident

____ **N**egotiated

GIVE (Keeping the relationship)

____ **G**entle

____No threats

____ No attacks

____ No judgements

____ **I**nterested

____ **V**alidated

____ **E**asy Manner

What reduced each of your effectiveness in the conflict? (Initial)

____ Lacking skills ____ Worry thoughts

____ Emotions ____ Indecision

____ Other describe: _____

_____

_____

Appendix O: Information Sheets for Emotion Regulation

Emotion Regulation: What is it?

Emotion regulation means: being in control of emotions with mindfulness and knowledge.

Goals of Emotion Regulation:

- Understand the Emotions you Experience.

  -Observe, describe, identify, and understand emotions.

- Reduce your Emotional Vulnerability.

  -Decrease amount of time you live in emotional mind state.

  -Increase positive emotions experienced.

- Decrease your Emotional Suffering.

  -Be mindful to deal with painful moments-in-the-moment.

  -If possible, use opposite action to change action or feeling.

What Do Emotions Do For You?

- Emotions Communicate to Others.

  -Facial expressions are part of emotions which tell others what our words do not.

  -The emotion behind our message influences others.

- Emotions Motivate Us.

  -Strong emotions get us moving and give us information about a situation. For example, "I am afraid. I need to get out of here."

Guidelines for Emotion Regulation

What to do to Increase Positive Emotions Experienced:

DO:

- Use mindfulness strategies.

  -Try to find something positive from each of your senses even if the situation is not positive.

- Try to put yourself into more positive situations where you will have good experiences.

  -Repair old relationships that mean something to you.

  -Reach out to make new friends.

  -Talk to a friend every day.

  -Make a list of positive things you like to do, and spend at least 20 minutes doing them each day.

  -Increase the amount of time you spend doing things that make you happy and calm.

  -Make a list of goals and take a small step towards these goals each day.

DON'T:

- Don't give up! Remember that everything changes.
- Focus on when this good time will end.
- Focus on whether or not you think you deserve this positive emotion.
- Focus on the future. Just enjoy the moment.

Appendix P: Teen Worksheet for Emotion Regulation

Write challenges or cheerleading statements that are counter arguments to the following myths about emotions:

1. Myth: I need to ignore painful emotions.

Challenge:_____

2. Myth: My painful emotions are because of my bad attitude.

Challenge:_____

3. Myth: My emotions can happen or change for no reason.

Challenge:_____

4. Myth: There is a right way for me to feel in every situation.

Challenge:_____

5. Myth: If others know that I am feeling bad, they will think that I am a loser.

Challenge:_____

6. Myth: Feeling angry is bad.

Challenge:_____

7. Myth: If others don't approve of how I feel, I shouldn't feel that way.

Challenge:_____

Appendix Q: Adult Worksheet for Emotion Regulation

Write challenges or cheerleading statements that are counter arguments to the following myths about emotions:

1. Myth: I should do my best to ignore painful emotions.

Challenge:_____

2. Myth: My painful emotions are the result of my failure as a person to be happy.

Challenge:_____

3. Myth: My emotions can happen for no reason.

Challenge:_____

4. Myth: There is a right way for me to feel in every situation.

Challenge:_____

5. Myth: If others know that I am feeling bad, they will think that I am weak.

Challenge:_____

6. Myth: Feeling angry is negative and destructive.

Challenge:_____

7. Myth: If others don't approve of how I feel, I shouldn't feel that way.

Challenge:_____

Appendix R: Family Worksheet for Emotion Regulation

As a group, write challenges or cheerleading statements that are counter arguments to the following myths about emotions:

1. Myth: We should do our best to ignore painful emotions.

Challenge:_____

2. Myth: Our painful emotions are the result of bad attitudes.

Challenge:_____

3. Myth: Our emotions can change for no reason.

Challenge:_____

4. Myth: There is a right way to feel in every situation.

Challenge:_____

5. Myth: If others know when we are feeling bad, they will think that we are weak.

Challenge:_____

6. Myth: Feeling angry is negative and destructive.

Challenge:_____

7. Myth: If others don't approve of how we feel, we need to change.

Challenge:_____

Appendix S: Information Sheets for Distress Tolerance

Distress tolerance means: to get through difficult situations that cannot be changed through distracting, relaxing, and utilizing coping skills without crisis.

Distress Tolerance Skills:

- Self-soothe with mindfulness and the five senses.

  -During the stressful event, find something positive from each sense in the moment.

  For example:

  -Smell: The smell of coffee brewing in the kitchen reminds you of your mom's kitchen.

  -Touch: The hardwood flooring under your feet is cool and smooth. You focus on the smoothness of it.

  -After the event, go do something that will soothe each sense.

  For example:

  -Sight: sit at the beach and watch the waves hit the shore.

  -Hearing: close your eyes and listen to your favourite song.

  -Smell: take yourself out for coffee and enjoy the aroma.

  -Taste: get some fresh squeezed orange juice and drink it mindfully.

  -Touch: wash your sheets and tuck them in tightly. Take a bath before going to bed so that everything feels fresh.

- Distract with **ACCEPTS** skills: remember, "The wise mind ACCEPTS."

  -**A**ctivities: Distract with exercise, hobbies, or time with friends.

  -**C**ontribute: Do something nice for someone else, or volunteer.

  -**C**omparisons: Compare yourself to others who are less fortunate.

  -**E**motions: Distract with opposite emotions. For example, go to a funny movie with a friend or read a romantic novel.

  -**P**ush away: Think about something else for the next little while.

  -**T**houghts: Distract yourself with puzzles, or count colours in a painting.

  -**S**ensations: Hold ice, squeeze a stress ball, or have a cold shower.

- Attempt to survive crisis moments: remember, "**IMPROVE** the moment."

  -**I**magery: Imagine that you are beside a beautiful waterfall. Watch as all of your hurtful emotions flow out of you down the waterfall.

  -**M**eaning: Make lemonade out of lemons and try to find something positive or some purpose for this pain.

  -**P**rayer: Open your heart to some higher power and turn things over to this power right now.

  -**R**elaxation: Tense and relax each muscle group. Breathe deeply.

  -**O**ne thing at a time: Be mindful of the moment.

  -**V**acation: Take a break for an hour or an afternoon to relax.

  -**E**ncouragement: "I can do it. I'm doing the best I can. This won't last forever, and it will get better."

Appendix T: Teen Worksheet for Distress Tolerance

Pros and Cons of Tolerating Distress

This is an example of a list of pros and cons of tolerating the distress when you have the urge to yell at someone.

	Pros	Cons
Coping and Using the Skills	-there is no fight -no argument starts -don't get in trouble -stay friends -get better at skills -others trust me -gain privileges for good behaviour	-there is no fight -I might not get my point across -others won't be afraid of me -I won't get that instant release -no rush from the feeling of yelling
Not Coping and Yelling	-others will leave me alone -others will be afraid of me -I will feel a rush or feeling of power	-I might lose self-esteem -consequences might be bad -I will have to go to counselling for longer -I might lose some friends -some people might not trust me

Think of an issue that you cannot change, and have to tolerate. List the pros and cons of coping and not coping in the situation.

	Pros	Cons
Coping and Using the Skills		
Not Coping and Yelling		

Appendix U: Adult Worksheet for Distress Tolerance

Pros and Cons of Tolerating Distress

The following is an example of the list of pros and cons of tolerating the distress when you have the urge to yell at someone:

	Pros	Cons
Coping and Using the Skills	-no argument is started -it can't escalate into a physical fight -don't get fired or divorced -keep friends -get better at skills -others trust me	-I might not get my point across -others might not listen -I might walk away feeling frustrated -no rush from the feeling of yelling
Not Coping and Yelling	-others will leave me alone -I will feel a rush or feeling of power	-I might lose self-esteem -consequences might be bad -I might have to go to counselling for longer -I might lose some friends or my job -some people might not trust me

Think of an issue that you cannot change, and have to tolerate. List the pros and cons of coping and not coping in the situation.

	Pros	Cons
Coping and Using the Skills		
Not Coping and Yelling		

Appendix V: Family Worksheet for Distress Tolerance

Pros and Cons of Tolerating Distress

The following is an example of the list of pros and cons of tolerating the distress when you are having a family conflict and have the urge to yell:

	Pros	Cons
Coping and Using the Skills	-there is no fight -no argument is started -don't get in trouble -family stays close -get better at skills -everyone trusts each other -kids gain privileges for good behaviour	-there is no fight -I might not get my point across -others might not listen -I won't get that instant release -no rush from the feeling of yelling
Not Coping and Yelling	-others will leave me alone -others will be afraid of me -I will feel a rush or feeling of power	-I might lose self-esteem -consequences might be bad -we will have to go to counselling for longer -family members might stop talking -family members might lose trust

Think of an issue that you cannot change, and have to tolerate. List the pros and cons of coping and not coping in the situation.

	Pros	Cons
Coping and Using the Skills		
Not Coping and Yelling		